DOCUMENT RESUME

ED 421 844 EC 306 615

AUTHOR	Whitney-Thomas, Jean; Timmons, Jaimie Ciulla; Thomas, Dawna M.; Gilmore, Dana Scott; Fesko, Sheila Lynch
TITLE	Changes in Vocational Rehabilitation Practice since the 1992 Rehabilitation Act Amendments.
INSTITUTION	Children's Hospital, Boston, MA. Inst. for Community Inclusion.
SPONS AGENCY	National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.; Administration on Developmental Disabilities (DHHS), Washington, DC.
PUB DATE	1997-12-00
NOTE	117p.
CONTRACT	H133B30067; 90DN0032
AVAILABLE FROM	Institute for Community Inclusion/UAP, Dissemination Coordinator, Children's Hospital, 300 Longwood Ave., Boston, MA 02115; telephone: 617-355-6506; TTY: 617-355-6956; e-mail: ici@a1.tch.harvard.edu.; World Wide Web: http://www.childrenshospital.org/ici ($10).
PUB TYPE	Reports - Research (143)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Acquired Immune Deficiency Syndrome; *Administrator Attitudes; Adults; Advocacy; *Counselor Attitudes; Cultural Differences; *Disabilities; Employment Services; *Federal Legislation; National Surveys; *Organizational Change; Racial Differences; Resistance to Change; Severity (of Disability); *Vocational Rehabilitation
IDENTIFIERS	*Rehabilitation Act Amendments 1992

ABSTRACT

This study sought to understand how the 1992 Rehabilitation Act Amendments have been implemented and whether practices since its passage have changed from the perspectives of vocational rehabilitation administrators and counselors as of 1996. Through the use of a national, cross-sectional survey, data were collected from 251 administrators and 254 counselors from 25 states. The research instrument was designed and organized to cover five topic areas noted in the 1992 Amendments: eligibility, use of existing information, consumer involvement, assistive technology, and accommodations serving those who have been underserved in the past. Results showed that administrators perceived significantly more change than counselors, and when asked how the 1992 amendments have had an impact on daily practice, neither group felt that more than "some change" had occurred in their offices or caseloads. Counselors and administrators perceived the least amount of change occurring in the AIDS knowledge area and the greatest change in consumer choice and advocacy. A large percentage of both administrators and counselors perceived change in the severity of disability of individuals served, however, only a small percentage perceived change in the cultural or ethnic diversity in their offices or their caseloads. (Contains 40 references.) (CR)

ED 421 844

CHANGES IN VOCATIONAL REHABILITATION PRACTICE SINCE THE 1992 REHABILITATION ACT AMENDMENTS

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Jean Whitney-Thomas
Jaimie Ciulla Timmons
Dawna M. Thomas
Dana Scott Gilmore
Sheila Lynch Fesko

December 1997

EC 306615

Changes in Vocational Rehabilitation Practice Since the 1992 Rehabilitation Act Amendments

Jean Whitney-Thomas

Jaimie Ciulla Timmons

Dawna M. Thomas

Dana Scott Gilmore

Sheila Lynch Fesko

December 1997

Institute for Community Inclusion
300 Longwood Avenue
Boston, Massachusetts 02115
(617) 355-6506
(617) 355-7940 (TDD)

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

Errata

Changes to Report: Whitney-Thomas, J., Timmons, J. C., Thomas, D., Gilmore, D. S., & Fesko, S. L. (1997). *Changes in Vocational Rehabilitation Practice since the 1992 Rehabilitation Act Amendments*. Boston: Institute for Community Inclusion (UAP), Children's Hospital.

Please note that the phrase "presumption of benefit" should be substituted for the phrase "presumption of eligibility" throughout the monograph.

Please also note that Elmer C. Bartels, Commissioner, Massachusetts Rehabilitation Commission, did not take part in the production of this monograph.

Acknowledgements

This is a publication of the Institute for Community Inclusion which is funded, in part, by the National Institute on Disability and Rehabilitation Research under grant #H133B30067 and the Administration on Developmental Disabilities under grant # 90DN0032. The opinions contained in this publication are those of the grantee and do not necessarily reflect those of the Department of Education.

The authors would like to thank the Council of State Administrators of Vocational Rehabilitation (CSAVR) for granting their support to this research. Thanks also go to Elmer Bartels, Commissioner, and other agency personnel from the Massachusetts Rehabilitation Commission, for their participation and feedback on multiple aspects of the project. The authors thank William Kiernan, John Butterworth, and Joseph Marrone of the Institute for Community Inclusion and Robert Schalock of Hastings College for their advice, feedback, and input to this research and final report.

The recommended citation for this report is: Whitney-Thomas, J., Timmons, J.C., Thomas, D.M., Gilmore, D.S., Fesko, S.L. (1997). *Changes in Vocational Rehabilitation Practice Since the 1992 Rehabilitation Act Amendments.* Boston: Institute for Community Inclusion (UAP), Children's Hospital

Additional copies of this report may be obtained for $10.00 per copy (postage and handling included). Direct orders to: Dissemination Coordinator, Institute for Community Inclusion, Children's Hospital, 300 Longwood Ave., Boston, MA 02115. 617 355-6506 ici@a1.tch.harvard.edu Please make checks payable to Children's Hospital.

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

Changes in Vocational Rehabilitation Practice Since the 1992 Rehabilitation Act Amendments

Table of Contents

Table of Contents i
Tables and Figures iii
Executive Summary v
Introduction 1
  Greater Access 2
    Reduced Timeline 2
    Emphasizing the Use of Existing Information 2
    Presumption of Eligibility 3
    Expanded Access to Populations Previously Underserved 3
  Consumer Involvement 4
  Improved Services 5
Method 9
  Sample 9
  Instrumentation 11
    Review of the Literature 11
    Focus Group Discussions 12
    Expert Panel Review 12
    Pilot-testing 12
  Research Design 13
    Analysis Procedures 13
    Statistical Analysis 14
    Variables 15
    Hypotheses 16
Findings 19
  Respondent Demographics 19
  Perceived Changes in People Served and VR Outcomes 20
    Change Perceived in Severity of Disability 20
    Changes Perceived in Cultural/Ethnic Diversity 20
    Changes Perceived in the Number of Successful Rehabilitations 21
    Changes in Perception of the Number of Unsuccessful Rehabilitations 22
  Perceived Change in VR Practices 23

Global Measure of Change....24
Changes in Specific Practice Areas....27
Item-by-item Analysis of Change....30
Correlation of Change Characteristics to Practice Areas....41
Discussion and Implications....45
Summary of Findings....45
Implications for Practice....47
Differences in Perception....47
Access....48
Consumer Involvement....49
Improved Services....50
Suggestions for Future Research....50
Consumer Perspectives....50
Ongoing Assessment....50
Baseline Data....51
References....53
Appendix A: Administrator Survey Instrument
Appendix B: Counselor Survey Instrument
Appendix C: Status Flow in the Vocational Rehabilitation Process

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

Changes in Vocational Rehabilitation Practice Since the 1992 Rehabilitation Act Amendments

Tables and Figures

Table 1. Listing of Participating States, Respondents, and Response Rates
Table 2. Description of Counselor Caseloads by Disability Category
Table 3. Changes in Racial and Ethnic Background of VR Consumer
Figure 1. RSA Data Tape Analysis of Outcomes Across Years
Table 4. Change Items Common to Both Administrator and Counselor Survey
Table 5. Differences on Global Measure of Change Between Administrators and Counselors
Table 6. Perceived Changes in Specific Practices Since 1992
Table 7. Differences Between Administrators and Counselors on Specific Areas of Change
Table 8. Listing of Survey Items and an Item-by-Item Analysis of Change
Table 9. Significant Differences in Practice Areas Reported by Those of Observed Change Characteristics

ICI
INSTITUTE FOR COMMUNITY INCLUSION

Changes in Vocational Rehabilitation Practice Since the 1992 Rehabilitation Act Amendments

Executive Summary

This study sought to gain an understanding of how the 1992 Rehabilitation Act Amendments have been implemented and whether practices since its passage have changed from the perspectives of vocational rehabilitation (VR) administrators and counselors as of 1996. Through the use of a national, cross-sectional survey, data were collected from 251 administrators and 254 counselors from 25 states. The research instrument was designed and organized to cover five topic areas as noted in the 1992 Amendments: eligibility, use of existing information, consumer involvement, assistive technology and accommodations and serving those who have been underserved in the past. Results from factor analysis, t-tests and ANOVAs revealed changes in daily VR practices since the implementation of the law in 1992. The results of this research were then compared to the Rehabilitation Service Administration's database (RSA-911 from federal fiscal years 1988, 1993 and 1995) to examine quantitative changes on key data elements over time and provide additional depth to the current investigation.

In general, results showed that administrators perceived significantly more change than counselors, and when asked how the 1992 Rehabilitation Act Amendments has had an impact on daily practice, neither group felt that more than "some change" had occurred in their offices or caseloads. Through a factor analysis of the change items common to both the counselor and administrator questionnaire, three internally consistent factors were identified. These were (1) Consumer Choice/Awareness, (2) Consumer Advocacy, and (3) AIDS Knowledge. Both counselors and administrators perceived the least amount of change occurring in the AIDS Knowledge area. Administrators perceived the greatest change in Consumer Choice and Advocacy. The greatest disparity in the perceptions of administrator and counselors is in the areas of Consumer Advocacy.

A large percentage of both administrators and counselors perceived change in the severity of disability of individuals served. These results make it clear that more individuals with severe disabilities have been determined eligible in the vocational rehabilitation system. However, only a small percentage of both administrators and counselors perceived change in the cultural or ethnic diversity in their offices or on their caseloads. For those respondents who did see a change in the cultural and ethnic diversity of the consumers they serve, these consumers were primarily Latin American, Asian American, and Native American. Increases in status 26 closures were noted by both groups, yet the two groups agreed that due primarily to the increase in efforts to serve the most severely disabled population and the 60 day eligibility determination, there was also an increase in the number of individuals not rehabilitated (status 28, 30).

Concerning changes in eligibility, the findings suggest that most applicants are being determined eligible within the 60 day time limit and that the mandated presumption of eligibility is being upheld in practice. Also, both administrators and counselors reported that there has been emphasis on the use of existing information. Both groups of respondents thought the most change occurred in the use of existing information over all other practice areas. An increase in consumer involvement in the development of the Individualized Written Rehabilitation Plan and the assessment process as well as a greater emphasis on consumer choice were also noted.

Both administrators and counselors felt that the consumer was also actively involved in developing assistive technology accommodations, although the rate of using assistive technology was low as reported in the survey. Despite the low numbers, however, administrators and counselors do see an increased use of assistive technology and accommodations, and attribute this change to the increased existence of such technology and an increase in specially trained staff.

The final practice area identified in the survey was the concept of serving individuals who have not been adequately served in the past. Administrators and counselors did agree that increased efforts and plans to target underserved groups are under development but have not been fully instituted. The increase in numbers of people with severe disabilities suggests that a greater number of individuals with severe disabilities, who may have previously been judged ineligible, have gained access to the vocational rehabilitation system. Both groups described an increased awareness and a focus on training around the needs of individuals with HIV, but only 33% of the counselors reported that they were aware of consumers on their caseloads as actually being HIV+ or having AIDS. In general, respondents saw the greatest increase in services to Latin-American, Asian and Native American cultural groups.

Further details of the changes observed by both administrators and counselors regarding these topical areas and others are presented in the following monograph. A comprehensive discussion of administrator and counselor perceptions will lead into implications for practice and culminate with suggestions for future research.

ICI

INSTITUTE FOR
COMMUNITY
INCLUSION

Chapter 1

Introduction

The first years of this decade saw a surge in the rethinking and redrafting of policy related to disability in this country. The Americans with Disabilities Act of 1990, the reauthorization of the Individuals with Disabilities Education Act in 1991, and the 1992 Rehabilitation Act Amendments comprise a body of anti-discrimination legislation and service priorities that emphasize greater access to services and full involvement of individuals with disabilities in community life and service delivery (Goodall, Lawyer, & Wehman, 1994; Weber, 1994). These laws were written through the collaborative efforts of people with disabilities, parents, professionals, elected officials, and those who felt an "emerging power... over their own lives and the services, programs, and laws which affect them" (Shreve, 1994, p. 8). This collaboration reflects an atmosphere of social activism, which sought to empower individuals with disabilities to have greater control over their lives, the services they need, and the level of inclusion in the broader community. National level activism resulted in drafting and passing the legislation of the early 1990's, which mandated social change in places of public accommodation, schools, and employment practice. As the decade draws to a close, it is appropriate to ask how the mandates have been implemented and how practices have changed as a result of this movement and legislation. A great deal of attention has been paid to the implementation and impact of the ADA since its passage in 1990 and its effect on employment and economic opportunity (Blanck, 1995; Klimoski & Palmer, 1993; Pati, & Bailey, 1995), education (Bowman & Marzouk, 1992; Wenkart, 1995), and inclusion in community life (National Council on Disability, 1995). Likewise, the implementation and impact of IDEA has been explored and reported (Apter, 1994; Guy, Merrill, & Johnson, 1993; National Council on Disability, 1996; Schriner, 1995). It is the purpose of this monograph to investigate the implementation of the Rehabilitation Act Amendments of 1992, through data collected in 1996. In order to provide context, however, we will briefly discuss what is known about the implementation of the ADA and IDEA.

The current study looks specifically at the implementation and impact of the 1992 Amendments to the Rehabilitation Act as of 1996. The Amendments were designed to bring vocational rehabilitation services into concert with the ADA, emphasize employment outcomes, and streamline the bureaucratic process of service provision (In the Public Interest, 1992). To remain aligned with other disability-related legislation of the early 1990's, the Rehabilitation Act Amendments intended to (a) increase access, (b) enhance involvement of the consumer, and (c) broaden the range of service to insure positive employment outcomes (Leuchovius & Parker, 1994). Practices to accomplish these goals were outlined in the law, but for the most part the Amendments established a spirit of change that was to be further delineated through regulations and rehabilitation practice. However, between passage of the Amendments in 1992 and the finalization of national regulations at the end of 1996, the Amendments themselves stipulated changes for daily vocational rehabilitation practice. Through an examination of the implementation of the Amendments prior to regulations, researchers can measure the extent to which the spirit of the law affected practice. This section will discuss how the Amendments have addressed (a) greater access, (b) consumer involvement, and (c) the improvement of services.

Greater Access

With the goal of helping greater numbers of individuals with disabilities obtain and maintain employment, the Amendments stipulated changes that would increase access to services. The law attempted to increase access by streamlining the eligibility process and by making an explicit commitment to serve those who have not been adequately served in the past. Changes in the eligibility process included (a) reducing the timeline to a maximum of 60 days, (b) emphasizing the use of existing documentation in the determination of disability status, (c) encouraging counselors to act under the presumption that applicants are eligible and will benefit from services, and (d) expanding access to populations previously underserved (In the Public Interest, 1992). Each of these components of the Amendment's new eligibility process will be examined in greater detail.

Reduced Timeline

The process of eligibility decision-making was changed in ways that would identify a greater number of individuals as eligible in a shorter amount of time and thereby expand services opportunities. The shortened timeline means that an eligibility decision must be made within 60 days following the consumer's initial contact with the vocational rehabilitation system. "The State Agency must make eligibility determinations within 60 days, unless exceptional and unforeseen circumstances exist that are beyond the control of the State Agency, and the individual concurs with the extension or an extended evaluation is required (In The Public Interest, 1992, p. 3)." If an extended evaluation period is used, an assessment must be made every 90 days to determine if the applicant has demonstrated that he or she can benefit from VR services (29 U.S.C.A. sec. 722 (a) (B)).

Emphasizing the Use of Existing Information

The use of existing information in eligibility decision-making was another change intended to streamline the entry process and help consumers gain access to the services and employment they seek. "Assessment information from other sources, including other agencies and individuals with disabilities and their families, is used in conducting the eligibility determination (Guy, Merrill & Johnson, 1993, p.14)." Counselors were encouraged to use pre-existing diagnostic information from physicians, psychologists, and other specialists to document the existence of a disability rather than purchase additional diagnostic services during the eligibility decision-making process. Along with the 60-day timeline, the use of existing information was meant to alter the rehabilitation process by focusing less on entry and more on the delivery of employment services.In keeping with the shortened eligibility timeline, the use of existing documentation was intended to reduce the number of obstacles encountered during the applicant's initial contact with the vocational rehabilitation agency.

Presumption of Eligibility

The presumption of eligibility is the third element in the eligibility process aimed at reducing the barriers that stand between consumers and their access to services within the rehabilitation system. Prior to the 1992 Amendments, "VR agencies were required to assess prospective clients for rehabilitation potential and future employability. This process often excluded individuals with very severe disabilities because VR counselors did not have reasonable expectation that services would result in gainful employment" (West, 1995, p. 281). The Amendments changed the language of the law to reflect a presumption of eligibility, which assumes that if one has a disability and is experiencing difficulty in securing employment, one can benefit from VR services. The law was also amended to mandate that if an individual is determined unable to benefit from services, the burden rests with the VR agency to document this inability to benefit. With the presumption of eligibility, the vocational rehabilitation agency has the responsibility to show that the individual is unable to benefit through the provision of clear and convincing evidence (1992 Amendments, 123(a)). This change should increase service opportunities to individuals with severe disabilities for whom VR services were formerly deemed inappropriate. According to Weber (1994), "Programs should become prepared to serve more persons whose very severe impairments render them unquestionably disabled and possibly able to benefit in terms of employment outcomes (p. 22)."

Expanded Access to Populations Previously Underserved

In addition to expanding access to individuals previously considered unable to benefit from services, the Amendments emphasize the need for VR agencies to serve people from other groups who have not been adequately served in the past, including racial and ethnic minorities (Goodall et al., 1994; Griffin, 1994, Weber, 1994). As Feist-Price (1995) indicated, a disproportionate number of African Americans received inadequate services within vocational rehabilitation. Differences related to race or ethnicity are apparent in accessibility, service delivery, and outcomes. The findings of Feist-Price indicate that "African Americans are under represented as rehabilitation applicants and clients when compared with disability prevalence data" (Feist-Price, 1995, p. 126). As a result, Griffin (1994) notes the ethical and legal responsibilities of the rehabilitation administration to facilitate and advocate for changes in service delivery that would result in improved rehabilitation services utilization by ethnic/racial groups. Therefore, the Amendments require VR agencies to extend outreach efforts into culturally and ethnically diverse communities and to provide necessary supports, which enhance consumers' experience with the VR system (Griffin, 1994).

Although the intent of the Amendments was to increase access to services, the law did not guarantee the availability of services once a consumer was deemed eligible. As noted by Schriner (1996), the Rehabilitation Services Administration realizes that the new eligibility guidelines will likely increase the number of individuals making it impossible to assure that services can be provided to all eligible individuals who apply. In these states, an order of selection must be established specifying (a) definitions of severity, and (b) mechanisms for serving those with the most severe disabilities first. Currently, 37 states have an order of selection process in place.

Consumer Involvement

Along with providing greater access to vocational rehabilitation services, a second focus of the 1992 Rehabilitation Act Amendments is to encourage "broad-based stakeholder involvement" (Goodall et al., 1994, p. 67) in both the rehabilitation process and the management of employment-related services. This emphasis on consumer involvement echoes the movement toward self-determination, empowerment, and choice-making opportunities of individuals with disabilities (Campbell, 1991; Harp, 1994; Curl & Sheldon, 1992). The 1992 Amendments seek to increase client choice of employment objectives, providers, and services (Weber, 1994, p. 25). The Amendments emphasize consumer involvement throughout the rehabilitation process as counselors and consumers work together to identify needs, skills, and employment goals.

At the very least, consumers should be actively involved in the development of their Individualized Written Rehabilitation Plan (IWRP), and their family members, advocates, or other representatives should be encouraged to participate in the planning process. For example, provisions of the IWRP include a requirement that the client states in his or her own words how the individual was informed of and involved in choosing among alternative goals, objectives, services, service providers and methods of providing or procuring services (Weber, 1994; Schriner, 1996; In The Public Interest, 1992; West, 1995). The IWRP must be designed to achieve the employment objective of the individual, consistent with his or her unique strengths or priorities, abilities, and capabilities, career goals and job preferences. (In The Public Interest, 1992; West, 1995). In addition, the IWRP "must be developed using the native language or mode of communication of the consumer and the consumer must be provided a copy" (West, 1995, p. 282).

The Amendments have not only created an environment where the consumer's involvement is important, but where consumer rights are paramount. It is the responsibility of the vocational rehabilitation system to inform applicants of their rights both under the Rehabilitation Act Amendments and the Americans with Disabilities Act of 1990. Client Assistance Programs must exist to assist consumers with advocacy, legal, and administrative advice, and with issues that directly relate to employment and facilitate access to services.

Consumer involvement throughout the entire VR process should culminate in a choice of services. The Rehabilitation Act Amendments mandate that strategies exist to make consumers aware of options and choices of services available to them. Applicants are encouraged to select the agency or vendor that will provide services and to be actively involved in choosing any necessary assistive technology or appropriate accommodations to facilitate successful employment. For example, a consumer may consider the use of a family member to act as a personal care assistant rather than seeking out a professional. As long as their functions are consistent with the IWRP, the consumer is now allowed to go outside the system if they feel it is in their best interest, as well as exercise choice or independence in the VR process (West, 1995, p. 282).

The increase in consumer involvement has "been matched by an increase in the collective power of persons with disabilities in the operation of rehabilitation service programs" (Weber, 1994, p. 25). The Amendments specify a broader role for consumers in developing the state rehabilitation plan and in evaluating agency performance (Schriner, 1996, p. 39). The 1992 Amendments create a climate where vocational rehabilitation clients and other individuals with disabilities "will have additional ability to affect state programmatic choices by participating in the newly-mandated State Rehabilitation Advisory Councils" (Weber, 1996, p. 25). This includes an assurance that the majority of seats on these advisory councils be held by individuals with disabilities, ultimately giving individuals greater influence over rehabilitation programming and service delivery. These kind of changes reflect the philosophy that people with disabilities should lead, manage, and operate the programs which are of benefit to them and should control the services, programs, and activities they need or wish to pursue (Shreve, 1994).

Improved Services

The final focus of the 1992 Rehabilitation Act Amendments includes an expansion of services related to supported employment, on-the-job training, personal assistance services, and a wide range of rehabilitation technology (Goodall et al., 1994, Weber, 1994). New "requirements concerning rehabilitation technology (formerly known as rehabilitation engineering) should help people with disabilities get the technology assistance they need during and after the rehabilitation process" (Guy et al., 1993, p. 15). States are now required to provide training to rehabilitation counselors, Client Assistance Program (CAP) staff and other related service personnel on assistive technology and accommodations (Guy et al., 1993, p. 15).

Changes were also made in the "supported employment provisions of the Act to help ensure that individuals with severe disabilities are provided these services" (Guy et al., 1993, p. 15). The 1992 Amendments emphasize the provision of supported employment services under Title I, the general pool of VR funds, rather than only under specific supported employment programs (Weber, 1994). As a result of the reauthorization, supported competitive employment is given greater emphasis within the context of Vocational Rehabilitation services. For many disability rights advocates this reframing was a step toward the ultimate goal of making segregated employment placements obsolete (West, 1995).

In addition, the reauthorization outlines explicit responsibilities of VR agencies in planning for and providing services during transition from school to work for eligible young people (Brown & Johnson, 1994, Guy et al., 1993, Goodall et al., 1994). The Amendments identify students who receive services under IDEA as one of the groups whose rehabilitation needs must be described in the state plan. In addition, the Amendments strengthen the language pertaining to interagency agreements and now require that such agreements be put in place with the state educational agency (Schriner, 1996). As part of these provisions, state VR systems must now track the number of students who are expected to graduate from high school each year as a way to insure VR counselor participation in the transition of students from the educational arena into the VR service delivery system. In addition, "new eligibility criteria were developed in part as a way to make special education students determined eligible for VR services" (Schriner, 1996, p. 49).

Finally, the Amendments emphasize the importance of personnel development to not only increase the number of qualified counselors but also improve the quality of service delivery (Weber, 1994). The 1992 Rehabilitation Act Amendments offer guidelines for policies that govern the delivery of VR services throughout the country through the creation of statewide professional standards for counselors and other rehabilitation professionals. These include activities for informing office personnel about the Rehabilitation Act Amendments, opportunities for counselor training and professional development, a system for evaluating counselor performance and strategies to recruit counselors from minority communities. Overall, the 1992 Amendments make changes in the training provisions of the law to "promote the upgrading of skills of existing rehabilitation personnel and the provision of training to persons with disabilities and their families..." (Weber, 1994, p. 23).

In general, the 1992 Amendments to the Rehabilitation Act are an expression of a renewed commitment to include individuals with disabilities in community life and improve access to employment opportunities. Given this ambitious agenda for change, however, Shreve (1994) questions how the "traditional system" (p. 8) can and will respond to the call for greater access, consumer empowerment, and improved services. Years after the mandate for these changes we are still left with questions as to whether these changes have found their way into local agency offices and the lives of individuals with disabilities. In order to fully comprehend the impact of this law on practice, an understanding of both administrator and counselor perceptions of change is required. Since there is evidence of different interpretations of the law (Whitney-Thomas & Thomas, 1996), the current investigation of change took this diversity into account. Through a comparison of change across different levels of the agency, researchers were able to consider the differing opinions when asked whether or not day to day practice has changed. The purpose of this study was to gain an understanding of how the amendments have been implemented as of 1996, and whether practice has changed from the perspective of service providers (i.e., administrators and counselors) on a national level. To address this goal the following research questions were asked:

(1) What are the most important elements in the 1992 Rehabilitation Act Amendments from the perspective of administrators and counselors?

(2) What has been the impact of the law on practice from the perspective of employees of the VR system?

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

Chapter 2

Method

This study used a national, cross-sectional survey methodology. Data were collected from a sample of Vocational Rehabilitation administrators and counselors about practices carried out in their offices and case loads since 1992. The analysis of the data employed both descriptive and *ex post facto* designs to address the research questions and hypotheses. This section will describe (a) the sample, (b) the instrumentation, and (c) the statistical analysis used in this research.

Sample

In order to initiate this research, the Council of State Administrators of Vocational Rehabilitation (CSAVR) was contacted to approve the research study. The purpose of this approval process was to clarify the goals of the research with this national advisory council. In turn, CSAVR approval of the research increased the participation from state commissioners and improved the response rate at a state level.

The first step in the sampling strategy was to randomly select 25 states and collect staff lists of both VR administrators and counselors from the Commissioners' offices in each of the sampled states. Each state contacted by the researchers agreed to participate in the study, and 23 out of the 25 provided the necessary staff lists. The two states that did not provide lists agreed to participate, but conducted their own random sampling of local office administrators and counselors through an arrangement made with the researchers. The states that participated are listed in Table 1.

From 25 states, random samples of administrators (total N = 321) and counselors (total N = 351) were mailed questionnaires. An intended sample size of no more than 400 administrators and counselors was chosen in order to insure that a large enough final sample would be available for data analysis with the expectation of a response rate of at least 50%. The number of sample members from each state varied and was based on the relative size of the state and its contribution to the U.S. population. The total Ns represent questionnaires mailed to 23 states after cleaning of staff lists and data entry.

Table 1
Listing of Participating States, Respondents and Response Rates

Participating States	# of Respondents		Response Rate (%)	
	Administrator	Counselor	Administrator	Counselor
Alaska	2	1	100	50
Alabama	11	10	79	63
Arkansas	7	6	88	75
Arizona	8	11	57	79
Delaware	1	1	50	50
Florida	21	22	45	44
Hawaii	0	1	0	25
Iowa	7	8	54	80
Indiana	17	12	77	60
Kansas	10	5	100	50
Kentucky	6	4	46	31
Massachusetts	13	8	62	38
Missouri	13	13	65	72
New Hampshire	2	2	67	67
New Jersey	7	14	58	52
New Mexico	4	5	57	83
Oregon	9	5	82	45
Pennsylvania *				
South Carolina *				
South Dakota	2	1	100	50
Texas	27	37	53	59
Utah	4	4	67	67
Virginia	10	15	63	68
Wisconsin	11	10	65	59
West Virginia	5	6	83	100
Total	197	201	61	57

* Note. Pennsylvania and South Dakota completed their own random sampling of local administrators and counselors. Eighty two surveys were sent to Pennsylvania and 24 surveys were sent to South Carolina. Out of those sent, 53 counselors and 53 administrators responded.

Because of the random selection procedures, the researchers are able to generalize the findings to a national population of VR personnel. In addition, the large sample size enhanced the stability of the descriptive data analysis and strengthens the power of theex *post facto* hypothesis testing. One disadvantage of this sample strategy was that the random sampling of administrators and counselors creates two independent samples. Therefore, the researchers are not able to link the data to any particular office. This is not a large disadvantage, however, since the intent of the project was to obtain a national response to implementation of the 1992 Rehabilitation Act Amendments.

In order to increase the response rate of the survey, the researchers used brightly colored paper for the questionnaire with the CSAVR approval number clearly printed on the cover letter. Finally, follow-up mailings were conducted that included a reminder postcard and a second mailing of the questionnaire to non-respondents. The final response rate for the study was 78% for administrators (n = 251) and 72% for counselors (n = 254).

Instrumentation

The questionnaire used in the research was developed specifically for this study. The researchers used a four step instrument development process, which enhanced the validity and reliability of the data being collected. The instrument development involved (a) a review of relevant literature, (b) focus group discussions, (c) feedback from a panel of experts, and (d) pilot testing of the instrument. See Appendixes A and B for copies of both the administrator and counselor versions of the questionnaire.

Review of the Literature

Instrument development began with a review of both existing and recent literature on the state VR system and the 1992 Rehabilitation Act Amendments. The literature review aided in the operationalization of the constructs or major ideas of concern in this study, particularly as they had been previously defined in other investigations. For example, the literature review helped the researchers identify the important areas of increased access to the VR service system, consumer involvement and the parts of the law that were aimed at the improvement of services. Through the literature review, the researchers also became aware of the need to involve individuals at multiple levels in the state VR systems for a comprehensive understanding of the Amendments and their implementation. Based on the literature review, a broad range of themes for questionnaire items and focus group topics were developed for use in the present survey. These themes translated into the survey sections, i.e. eligibility, use of existing information, consumer involvement, assessment and the IWRP, assistive technology and accommodations, and serving those who have not been adequately served in the past. The administrators' questionnaire also included sections on personnel and agency management, and interagency information and services.

Focus Group Discussions

Four focus groups were conducted to insure that the survey captured the breadth of the law and was meaningful to both administrators and counselors in the state VR system. An additional goal of the groups was to gain a better understanding of the Amendments and the subsequent changes that have occurred in VR practice.

It has been recommended that focus group participants be relatively homogeneously grouped, as individual participants are more likely to feel comfortable in sharing personal information and experiences in groups comprised of peers (Knodel, 1993; O'Brien, 1993; Jarret,1975). Therefore, the focus groups were arranged so that individuals who shared common experiences and similar backgrounds in the VR system participated together. The first group comprised VR administrators at the central office level (n = 3). A second focus group comprised area and local office administrators (n = 5). The third group was made up of VR counselors (n = 3). Finally, a focus group of consumers (n = 4) was convened.

The focus group discussions were led by the first and third authors, taped, transcribed, and analyzed as qualitative data (Bertrand, Brown, & Ward, 1992). Discussion protocols were used and consisted of a list of broad questions pertaining to the 1992 Rehabilitation Act Amendments and their implementation. The protocols were meant merely to keep the participants focused and not to elicit specific information (Knodel, 1993).

Expert Panel Review

Once a pool of items for the questionnaires had been generated, drafts were created and reviewed by a 12 member expert panel in order to assess content and construct validity (DeVellis, 1991). The panel was made up of Vocational Rehabilitation professionals, consumer advocates, and researchers with expertise in vocational rehabilitation as well as survey research and design. The panel was asked (a) to assess the clarity of the questionnaires; (b) whether the items accurately reflect the purposes of the study; (c) which items were redundant, and (d) to suggest items or topics that should be added. The questionnaires were subsequently revised according to the feedback gained from the expert panel.

Pilot-testing

The final step in the development of the questionnaires was a pilot test to insure that the questions were worded appropriately, the directions were clear, and the completion time was reasonable (Fink & Kosekoff, 1985). The questionnaire was piloted with a small sample of local VR office administrators and counselors who are not part of the final survey sample. The pilot participants were asked to: (a) rate the clarity of the questionnaires on a four-point scale from "not at all clear" to "very clear"; (b) indicate whether any questions seemed repetitive; (c) determine if there were important issues that had not been addressed; and (d) indicate how long it took them to complete the questionnaires. The feedback from the pilot-test was incorporated into the final questionnaire. Pilot test participants indicated that the questionnaires took an average of 30 minutes to complete.

Research Design

The research involved three primary designs. The research was primarily descriptive, that is, describing existing groups and conducting data reduction techniques to respond to research questions. The researchers also used an *ex post facto* design , which tested hypotheses of differences between groups on their perspectives of changes in rehabilitation practice. The third design used in this study was secondary analysis of the RSA 911 data tapes to compare the reported change on the questionnaires developed for this study with closure data collected yearly by the VR system (in the current study, secondary analysis was performed on 911 data from FY 1988, 1993, and 1995). In the following section we will discuss the (a) analysis procedures, (b) statistical analysis, (c) variables, and (d) hypotheses used in the study.

Analysis Procedures

In order to gain more information from the data that were collected with the questionnaires, the researchers looked at the data in a number of ways. The data were summarized and condensed to understand the respondents as a group and to reduce the data into subscales, which were then used in hypothesis testing. First, the researchers wanted to learn about administrators' and counselors' interpretations of the Amendments and how these interpretations could be seen in their response patterns. In order to accomplish this, factor analysis was used as a "first cut" at analyzing the items to which both counselors and administrators responded. The factor analysis resulted in subscales that we refer to as "factors" throughout the monograph. Administrators and counselors were compared on their responses to the factors. The "second cut" of the data involved examining responses to the survey according to the sections that existed on the questionnaires. This was done in order to more fully use the data that were collected and to understand administrators' and counselors' perspectives on change in areas specified in the Amendments. The existing sections of the questionnaires were used as subscales and we refer to these subscales as "areas of change" below. Administrators and counselors were compared in their responses to the areas of change. The final cut considered the area of change in relation to four discrete items at the beginning of each questionnaire. These items asked the administrators and counselors whether changes had occurred in the number of people successfully rehabilitated, the number of people unsuccessfully rehabilitated, the ethnic and racial diversity of consumers, and the severity of disabilities of consumers. Comparisons of responses to questionnaire subscales (i.e., areas of change) were made between those who reported change on these items and those who did not. A complete discussion of variables in this study can be found on page 21.

Since no quantitative measures of changes in closure data were included on the survey, an independent data source, namely the Rehabilitation Services Administration (RSA)-911 data, was used to examine quantitative changes on key data elements over time and to clarify the nature of changes in practices reported by the administrators and counselors in the study. The 911 data is RSA's annual case service report system. Each year, data on all vocational rehabilitation closures (whether successful or not) are gathered and compiled by RSA. After being compiled, the data are available upon request for public use. This data presents an accurate picture of the composition of closures from the 50 state VR service systems, the District of Columbia, and six US territories. The RSA 911 variables used in the secondary analysis were chosen because of their similarity to items and subscales in the current study.

Statistical Analysis

The descriptive component consisted of summary statistics and factor analysis. Means and standard deviations for the questionnaire items were calculated where appropriate. There were 36 questionnaire items on the administrator survey and 24 items on the counselor survey that asked respondents to rate the degree to which they felt a given practice had changed since the 1992 Amendments. Each item was rated on a three point scale with 1 representing no change and 3 representing a great deal of change. The 21 common three-point items on both administrator and counselor versions were analyzed as a unified scale. Internal consistency was estimated using Cronbach's alpha.

Factor analysis of the common three-point items was also performed in order to reduce the data to grouping of items that reflect changes in rehabilitation practice. The factor analysis was performed on SPSS for Macintosh and used Principle Axis Factoring (PAF) extraction as recommended for inferential statistics by Snook and Gorsuch (1989). Examination of the scree plot of eigen values suggested the number of factors that should be retained and a VARIMAX rotation of the initial solution allowed the researchers to name the groupings of questionnaire items.

The hypothesis testing or ex post facto component of the study consisted of testing differences between administrators and counselors on the subscales identified in the descriptive analysis (factors and areas of change). In addition, hypotheses differences were tested between those respondents who reported changes in the population of consumers served and rehabilitation outcomes on the subscales (factors and areas of change). The specific variables and hypotheses will be described below.

Data from RSA's annual report to the President and Congress show approximately 900,000 people served by RSA each year. The number of closures, as reported in the RSA-911 database, averages about 610,000 each year. Any inference testing, e.g. chi-square analysis, will be affected by such large numbers. Because a change of only one percent over a single year could represent 60,000 people, these kinds of changes lead to very large, significant chi-square values. As the RSA-911 database is essentially a universal data set, i.e. all closures from the VR system for a single year, data over time are presented in table and graphical format for inspection and interpretation. No parametric or non-parametric tests were run on the RSA 911 data presented in this monograph.

Variables

The first variable identified in the descriptive analysis was a global measure of change in vocational rehabilitation practice, which was calculated using scores from the 21 three-point items common to both administrators and counselors. This variable is referred to as the*global measure of change,* and ranged from "no change" to "a great deal of change" along a three point Likert scale.

Three additional variables (*factors*) were identified from the factor analysis and called: Consumer Empowerment and Choice, Services for Individuals with HIV or AIDS, and Consumer Involvement. Mean factor-based scores were calculated by summing the responses to the questionnaire items that comprised each factor (Pedhazur & Schmelkin, 1991). Each item was measured on the same three point Likert-type change scale on both administrator and counselor questionnaires. The factors are described in detail in the Results section.

In addition to the three factors representing change in VR practices, the groupings of items in each section of the questionnaire were also used as subscales (*areas of change*) in order to examine changes in practice using a broader range of practices than emerged from the factor analysis. Items were grouped into the following questionnaire sections: (a) Eligibility, (b) Use of Existing Information, (c) Consumer Involvement, Assessment and the IWRP, (d) Assistive Technology and Accommodations, and (e) Serving Those That Have Not Been Adequately Served in the Past. Each of these subscales was used as a variable by calculating mean scale-based scores and were measured on the same three point Likert-type change scale.

The primary grouping variable used in the*ex post facto* portion of the study was the respondents' position within the VR agency. *Position within the agency* was defined as a categorical variable with two levels: administrator and counselor. This variable was used to test hypotheses of difference on the global measure of change and the subscales including the factors and the questionnaire subsections describing areas of change.

Respondents were also asked whether they felt their caseload or consumer population had changed in racial or ethnic diversity, in severity of disability, and if the numbers of consumers successfully rehabilitated and unsuccessfully rehabilitated had changed since 1992 (*change characteristics*). These four variables (Racial/Cultural Change, Severity of Disability Change, Changes in Status 26, and Changes in Status 28,30) were all categorical with three levels: (1) yes, change has occurred, (2) no, change has not occurred, and (3) unsure whether change has occurred. For the purposes of hypothesis testing, only the data from those who responded yes or no to these change items were used in the analysis. These were used as grouping variables.

Within each subsection of the questionnaire, counselors were asked to report on services provided for their last 10 consumers (either in active status or closures, depending on the questionnaire item). This data gave the researchers a sense of how frequently the services described in law were being implemented in practice. This data was not used in hypothesis testing but is reported as descriptive data in the item-by-item analysis section of this monograph, which explains how the major components of the Amendments are being implemented.

Both counselors and administrators were asked to clarify their responses to the three-point change items with written comments. Respondents were encouraged to explain what exactly the nature of the change is that they report. They listed practices, strategies, and specific examples of how practices are carried out in day-to-day work. In these write-in sections, respondents also explained if changes have not occurred and why. For example, many people stated that the given practice was already in place before the Amendments and therefore they could not report a change.

Finally, for the quantitative secondary analysis, a specific set of variables from three distinct time periods were chosen from the RSA-911 database. The years analyzed were federal fiscal years 1988, 1993, and 1995 giving the researchers a "before and after" window on practice related to the Amendments. Variables from the RSA-911 database were chosen to provide data that was as comparable as possible to the issues highlighted in the questionnaire (a status code flow chart is included in Appendix C). The variables chosen were:

(1) Severe disability, a binary coding indicating whether or not the individual has a severe disability,

(2) Race and Hispanic origin,

(3) Type of closure, specifically (a) Not accepted for services from the applicant status (status 08 from status 02), (b) Not accepted for service from extended evaluation (status 08 from status 06), (c) Rehabilitated (status 26), (d) Not rehabilitated, after individualized written rehabilitation program (IWRP) initiated (status 28), and (e) Not rehabilitated, before IWRP initiated (status 30),

(4) Reason for not accepted or not rehabilitated (specifically those listed as handicap too severe or unfavorable medical prognosis, and

(5) Work status at closure (competitively employed and sheltered workshop).

The data from the RSA-911 data tapes were used in a descriptive fashion as a point of comparison to the data collected for the current study and were not used in hypothesis testing.

Hypotheses

A series of hypotheses were tested on differences between groups on their perceptions of change as measured by the global change measure, the three change factors, the area of change subscales, and the four change characteristics. Univariate t-tests were used for each hypothesis with a pre-set alpha of .05. The following hypotheses were tested:

- Administrators and counselors differ on their responses to the global measure of change.

- Administrators and counselors differ on their responses to specific factors defined as Consumer Choice/Awareness, AIDS Knowledge, and Consumer Advocacy.

- Administrators and counselors differ on their responses to the areas of change specified in the questionnaire as eligibility, use of existing information, consumer involvement, assessment and the IWRP, assistive technology and accommodations, and serving those that have not been adequately served in the past.

- Administrators and counselors differ on their responses to level of change on each individual practice item.

- Those who did and did not report changes in the severity of disability of the clients they serve differ on responses to items related to eligibility, use of existing information, consumer involvement, assessment and the IWRP, assistive technology and accommodations, and serving those that have not been adequately served in the past.

- Those who did and did not report changes in the racial or ethnic background of the clients they serve differ on responses to items related to eligibility, use of existing information, consumer involvement, assessment and the IWRP, assistive technology and accommodations, and serving those that have not been adequately served in the past.

- Those who did and did not report changes in the number of successful rehabilitation closures differ on responses to items related to eligibility, use of existing information, consumer involvement, assessment and the IWRP, assistive technology and accommodations, and serving those that have not been adequately served in the past.

- Those who did and did not report changes in the number of unsuccessful rehabilitation closures differ on responses to items related to eligibility, use of existing information, consumer involvement, assessment and the IWRP, assistive technology and accommodations, and serving those that have not been adequately served in the past.

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

Chapter 3

Findings

Respondent Demographics

The vast majority of administrators (92%) and counselors (93%) were Caucasian. Only six percent of the administrators and five percent of the counselors identified their ethnic/racial background as Black, and an even smaller percentage (4%) of both administrators and counselors reported being of Hispanic origin. Slightly more than half (54%) of the Vocational Rehabilitation counselors were female, whereas the majority (72%) of the administrators were male.

Forty-one percent of the counselors classified the environment served by their office as primarily urban/suburban, rather than rural (24%). Forty-seven percent of administrators described their offices as delivering services to both urban/suburban and rural geographic areas.

In addition, Vocational Rehabilitation counselors were asked to describe their current caseloads. Counselors reported an average active caseload of 117 individuals in all active status categories with responses ranging from 40 to 400. The majority of counselors (79%) described their caseloads as comprising individuals with varying disabilities. The least represented population on active counselor caseloads were individuals with HIV/AIDS. Additional details on counselor caseloads can be seen in Table 2.

Table 2
Description of Counselor Caseloads by Disability Category

Disability Category	# of Counselors Serving Individuals with these Disabilities	% of Counselors Serving Individuals with these Disabilities
Serve a Caseload with a General Mix of Consumers	201	79
Substance Abuse	119	47

ADD/LD/ADHD	113	45
Severe Mobility Impairment	109	43
Traumatic Brain Injury	106	42
Other (psychiatric, sensory impairments, mental retardation)	106	42
HIV/AIDS	47	19

Perceived Changes in People Served and VR Outcomes

Both administrators and counselors were asked to report whether or not they perceived change in the types of individuals served and VR outcomes. More specifically, administrators were asked whether people served or status codes had changed in their *office* since 1992, whereas counselors indicated ways in which their *caseload* had changed since 1992. In order to further clarify these change areas, both administrators and counselors responded to four survey items hereafter referred to as *change characteristics.* Two of these change characteristics were related to aspects of individuals served, while the other two were associated with change in status code trends or VR outcomes. The four change characteristics are as follows: severity of disability, cultural or ethnic diversity, number of people closed "rehabilitated" (status 26) in a year, and the number of people closed "not rehabilitated" (status 28, 30) in a year.

Change Perceived in Severity of Disability

The first change characteristic was whether or not administrators and counselors perceived changes in the severity of disability of the individuals served since 1992. A large percentage of both administrators (69%) and counselors (65%) perceived a change in the severity of disability of individuals served. Counselors described serving more people with severe disabilities without indicating a causal factor, whereas administrators described serving more people with severe disabilities specifically due to the implementation of the order of selection. These findings are consistent with the RSA 911 data tapes which indicate that the percentage of individuals with severe disabilities increased from 51% of all closures in 1988 and 56% of all closures in 1993 to 66% of all closures in 1995.

Changes Perceived in Cultural/Ethnic Diversity

In addition to the perception of change in serving individuals with severe disabilities, respondents were asked whether they have seen change in the cultural or ethnic diversity of individuals served. In general, administrators and counselors did not report changes in the racial or ethnic backgrounds of the people they serve. Only nine percent of the counselors perceived a change in cultural or ethnic diversity on their caseload since 1992. Of the counselors who did perceive change, the majority reported an increase in serving Latino, Asian and Native American populations. Slightly more administrators (22%) observed change in cultural or ethnic diversity, and commented primarily on an increase in serving the same groups. Likewise, the RSA 911 data tapes show little if any increase in the numbers of individuals who are Afro-American, American Indian, Asian/Pacific Islander, or of Hispanic background (see Table 3).

Table 3
Changes in Racial and Ethnic Background of VR Consumers

	Percent of Consumers		
Background	**1988**	**1993**	**1995**
White	78.3	77.1	76.9
Afro-American	19.8	20.7	20.6
American Indian	.8	.9	1.0
Asian/Pacific Islander	1.2	1.3	1.5
Hispanic origin	7.4	8.3	8.8

Note. Data taken from RSA-911 database.

Changes Perceived in the Number of Successful Rehabilitations

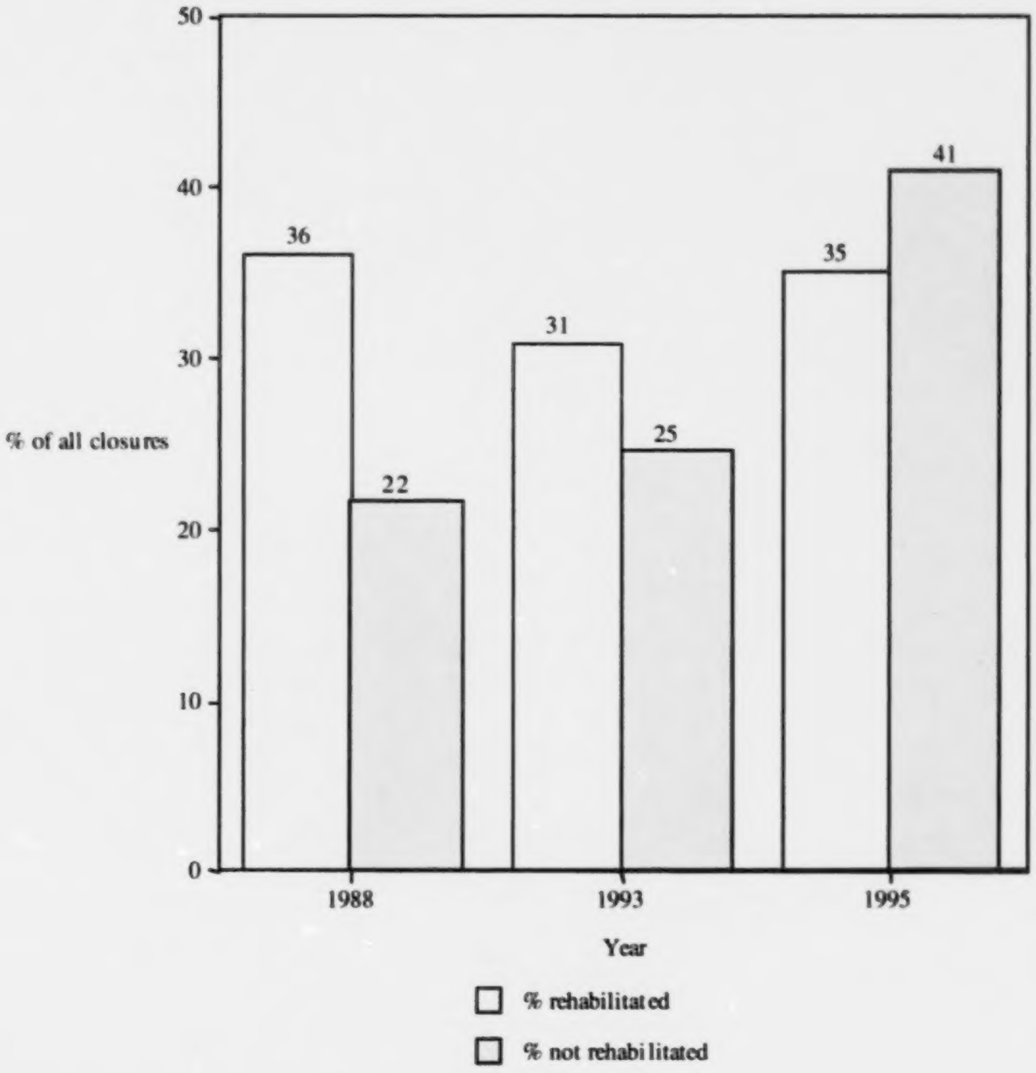
Respondents were also asked to comment on changes in VR outcomes. As a group, both administrators and counselors said change had occurred. Both administrators and counselors presented their perceptions of change on the number of people successfully closed or "rehabilitated" (status 26). A substantial number of counselors (44%) saw a change in the number of people rehabilitated on their caseload. Most described an increase in status 26 closures due to larger caseload size, increased knowledge of casework and better job contacts. It is interesting to note that of the 44% of the counselors who perceived change, 10 counselors described a decrease in closures due to the increase in serving individuals with severe disabilities, a waiting list to provide services, and a decrease in the length of time to train and place individuals they serve.

Slightly more than half of the administrators (58%) saw a change in the number of people "rehabilitated" (status 26) in their office in a year since 1992, but did not describe the change as drastic. Respondents were equally divided as to whether there was an increase or decrease in status 26 closures, but both referred to the change as slight. For administrators that observed an increase in the number of individuals rehabilitated, many accounted for this through an increase in competitive employment opportunities, an increase in counselor caseloads and an increase in job placement among individuals with severe disabilities. This result is also consistent with the RSA 911 data which indicates that numbers of people rehabilitated went down from 1988 to 1993, but then increased from 1993 to 1995 (see Figure 1).

Changes in Perception of the Number of Unsuccessful Rehabilitations

Respondents were also asked whether they perceived change in the number of individuals "not rehabilitated" (status 28, 30). Slightly fewer counselors (36%) than administrators (39%) saw a change in the number of status 28 or 30 closures on their caseload or in their office since 1992. The counselors and administrators that reported change described an increase in the number of individuals that had not been rehabilitated. The two groups agreed that this increase was primarily due to efforts to serve the most severely disabled population and the sixty day eligibility determination requirement. Several counselors added that because of the swift eligibility determination, clients subsequently had difficulty when attempting to follow through with the IWRP. This result remains consistent with RSA 911 data from 1988, 1993, and 1995 that show a steady increase in the percentage of unsuccessful rehabilitations out of all closures across these years (See Figure 1). When one considers that the "not accepted" rate decreased from 45% in 1993 to 25% in 1995, one can suggest that the explanation for the large increase in numbers of people not rehabilitated in 1995 may be that many of the people who were formerly not accepted for services are currently being accepted for services but are not being successfully closed.

Figure 1
RSA Data Tape Analysis of Outcomes Across Years



Note. Data taken from RSA-911 database.

Perceived Change in VR Practices

Analysis of changes in VR practices was performed using internal consistency estimates (Cronbach's alpha) and factor analysis of the three-point items described in the methods section. The analysis resulted in three primary ways of describing changes in VR practice since 1992. First, a global measure of change was created using all the items common to both administrators and counselors. This global measure was used to document general perceptions of change and to test for differences between the administrators and counselors. The second description of change involves specific topical areas that emerged through a factor analysis of the items common to both administrators and counselors. Finally, perceptions of change were analyzed via descriptive statistics for each item on the survey and the written responses on how changes have occurred in daily practice.

Global Measure of Change

Administrators and counselors both responded to 21 items that measured change on a three point scale concerning VR practices since 1992. These items are listed in Table 4. By summing the participants' responses to these items and dividing by the number of items, the researchers could arrive at a global measure of change in VR practices since 1992. The reliability coefficient (Cronbach's alpha) of this global change scale is .89, which represents good internal consistency and justifies the use of the scale as a global measure of change in hypothesis testing. As can be seen by the means presented in Table 4, counselors and administrators felt that, in general, some change had occurred in these practices since 1992, although some counselors and administrators reported in their written comments on the questionnaire that they had been doing these practices before the passage of the 1992 Rehabilitation Act Amendments.

Table 4

Change Items Common to both Administrator and Counselor Surveys

Survey Item	Mean	
	Administrator	Counselor
Presumption that applicant will benefit	2.32	1.96
Methods to document that individual would not benefit	2.21	1.97
Yearly re-evaluation of individuals judged ineligible	1.34	1.31
Formal process for consumers to appeal ineligibility	1.45	1.22
Use of existing information from other sources	2.31	2.04
Consumers' responsibility for providing existing information	1.92	1.68
Consumer assessment occurs after eligibility determination	1.76	1.67
Active consumer involvement in the IWRP process	1.85	1.67
Active involvement of family and others in the IWRP process	1.60	1.38
Conducting planning and assessment in the consumer's native language	1.52	1.20
Use of alternative formats in assessment/planning	1.50	1.16
Activities to inform consumers of rights under the Rehab Act Amendments	1.79	1.60
Activities to inform consumers of rights under the ADA	1.84	1.73

Strategies to make consumers aware of options and choices	2.05	1.77
Consumer choice of agency/vendor to provide services	1.91	1.73
Placement opportunities in integrated environments	1.91	1.70
Provision of assistive tech and/or accommodations throughout the rehab process	2.05	1.65
Consumer involvement in developing assistive tech/accommodations	1.86	1.63
Outreach efforts to groups underserved in the past	2.00	1.70
Efforts to address the rehab needs of individuals with HIV/AIDS	1.54	1.44
Technical assistance to employers regarding employees with HIV/AIDS	1.40	1.24

Displayed in Table 5 are the results of a test for differences between administrators and counselors on their perceptions of global change. These findings indicate that administrators perceived significantly more change than did counselors when asked whether or not the 1992 Amendments has had an impact on daily practice in their office or caseload. Neither group, however, felt that a great deal of change had occurred. In order to understand the nature of this change better and to see where administrators and counselors differed the most, additional analysis of the three-point change items was performed.

Table 5

Differences on Global Measure of Change Between Administrators and Counselors

Group	N	Mean	SD	t(df)	p

Counselor	242	1.60	.34	-6.63	.000
Administrator	249	1.82	.39	(1, 482)	

Changes in Specific Practice Areas

A factor analysis of the change items common to both the counselor and administrator questionnaires revealed three internally consistent factors (alpha .75). These factors represent specific areas of change perceived by both administrators and counselors and were used to test further hypotheses of difference between the two respondent groups. The items that comprise each factor are presented in Table 6. The factor loadings reported in the table indicate the strength of the relationship of each item to its factor.

Table 6

Perceived Changes in Specific Practices Since 1992

Name of Factor			**Means (SD)**	
Items in Factor	**Factor Loadings**	**Internal Consistency (Cronbach's Alpha)**	**Admin.**	**Counsel.**
Consumer Choice/Awareness:		.81		
Consumers involved in IWRP	.66		1.85 (.74)	1.67 (.72)
Consumers aware of service options	.78		2.05 (.72)	1.77 (.72)
Consumer has choice in rehab. provider	.81		1.91 (.75)	1.73 (.72)
Integrated employment opportunities	.53		1.91 (.78)	1.70 (.74)
Consumer Advocacy:		.79		
Formal appeal process	.62		1.45 (.67)	1.22 (.49)
Family/advocate involved in IWRP	.63		1.60 (.66)	1.38 (.58)
Assessment/planning in native language	.46		1.52 (.68)	1.20 (.49)
Assessment/planning in alternative formats	.61		1.50 (.68)	1.16 (.43)
Informing consumers of rights	.56		1.79 (.72)	1.60 (.65)
Informing consumers of ADA	.46		1.84 (.66)	1.73 (.71)
AIDS Knowledge:		.75		
Outreach to HIV/AIDS consumers	.84		1.54 (.64)	1.44 (.64)
TA to employers about HIV/AIDS issues	.84		1.40 (.57)	1.24 (.49)

As in the case of the global change measure, the strong internal consistency estimates listed in Table 7 justify the use of these factors as variables in the hypothesis tests to be described below. The factor loadings also help determine the nature of the factors and to identify their relationship with the Amendments in order to name them. The factors that emerged from the analysis describe areas of change prescribed by the 1992 Amendments. The 1992 Rehabilitation Act Amendments emphasized an increase in consumer control of rehabilitation process, and outreach to groups who had previously been under-served by the vocational rehabilitation system. The Consumer Choice/Awareness and Consumer Advocacy factors echo the theme of consumer control and empowerment in the law. The AIDS Knowledge factor can be understood as a component of the mandate to better serve previously underserved populations. As evident in the mean levels of change in the three factors, neither group of respondents felt that a great deal of change has occurred in any of the areas. Nevertheless, administrators see the greatest change in Consumer Choice/Awareness and the least amount of change in the AIDS Knowledge area. The greatest disparity in the perceptions of administrators and counselors is in the areas of Consumer Advocacy.

Table 7

Differences between Administrators and Counselors on Specific Areas of Change

Area of Change	N	Mean (SD)	t(df)	p
Consumer Choice/Awareness:				
Counselor	239	1.72 (.58)	-3.96	.000
Administrator	249	1.93 (.59)	(1, 486)	
Consumer Advocacy:				
Counselor	239	1.43 (.43)	-5.38	.000
Administrator	249	1.65 (.50)	(1, 480)	

AIDS Knowledge:				
Counselor	229	1.35 (.52)	-2.37	.018
Administrator	245	1.47 (.54)	(1, 472)	

Item-by-item Analysis of Change

The questionnaire was constructed to cover broad topic areas written about in the 1992 Amendments. Administrators responded to items related to personnel and agency management and interagency information and services. Additional topic areas included eligibility; use of existing information; consumer involvement, assessment, and the IWRP; assistive technology and accommodations; and serving those who have not been adequately served in the past. A more detailed listing of survey items and an item-by-item analysis of change can bee seen in Table 8.

The topic areas were developed through the literature review and focus groups used in the instrument development phase of the research. They reflect important areas of change specified in the Amendments and gave the respondents a framework in which to describe their service delivery since 1992. In addition to rating the degree of change along the three-point scale, both administrators and counselors were asked to describe how these changes have taken place. Counselors were also asked a series of questions about the last 10 consumers they worked with. Both the write in responses and the numerical data gave the researchers additional information on how the practices are being implemented.

Table 8

Listing of Survey Items and an Item-by-Item Analysis of Change

	Mean Change (SD)	Alpha	Hypothesis tests of Difference between Counselors' and Administrators' ***
Personnel and Agency Management		.68	Admin. only items
Activities for informing personnel on the Rehab. Act Amendments*	2.14 (.76)		
State-wide professional standards for	1.62		

counselors and others **	(.75)		
Opportunities for counselor training and professional development**	1.87 (.75)		
A system for evaluating counselor performance **	1.76 (.73)		
Strategies to recruit counselors from minority communities**	1.55 (.66)		
Interagency Information and Services		.75	Admin. only items
Formal interagency groups/agreements to facilitate service delivery**	2.04 (.74)		
Counselors take part in student transition from educational to VR services **	2.20 (.72)		
Encouraging non special ed young adults to access VR services **	1.63 (.69)		
Tracking the number of expected high school graduates each year **	1.59 (.72)		
Agency's community exposure to broaden referral sources**	1.90 (.73)		
Eligibility		.61	Admin. = 1.8, Coun. = 1.6 t = -5.14 (1, 487), p = .000
Monitoring cases extending beyond 60-day limit**	2.60 (.65)		
Presumption that applicant will benefit	2.14 (.78)		-.36
Methods to document that individual would not benefit	2.10		-.24

	(.77)		
Yearly re-evaluation of individuals judged ineligible	1.32 (.62)		-.03
Formal process for consumers to appeal ineligibility	1.34 (.60)		-.23
Use of Existing Information	.	.61	Admin. = 2.1, Coun. = 1.9 t = -4.88 (1, 487), p = .000
Use of existing information from other sources	2.18 (.75)		-.28
Consumers' responsibility for providing existing info	1.80 (.69)		-.24
Consumer Involvement, Assessment and the IWRP		.87	Admin. = 1.8, Coun. = 1.6 t = -5.05 (1, 484), p = .000
Consumer assessment occurs after eligibility determination	1.72 (.72)		-.09
Active consumer involvement in the IWRP process	1.76 (.73)		-.18
Active involvement of family and others in the IWRP process	1.49 (.63)		-.22
Conducting planning and assessment in consumer's native language	1.37 (.61)		-.32
Use of alternative formats in assessment/planning	1.34 (.60)		-.34
Consumer satisfaction assessment and necessary changes in services **	2.00 (.74)		

Activities to inform consumers of rights under Rehab. Act Amendments	1.69 (.69)		-.19
Activities to inform consumers of rights under the ADA	1.79 (.69)		-.12
Consumer advisory board's role in implementing Amendments**	1.94 (.76)		
Client Assistance Programs to help consumers with advocacy, etc. **	1.56 (.71)		
Strategies to make consumers aware of options and choices	1.92 (.73)		-.28
Consumer choice of agency/vendor to provide services	1.82 (.74)		-.18
Placement opportunities in integrated environments	1.80 (.77)		-.21
Assistive Technology and Accommodation		.75	Admin. = 2.0, Coun. = 1.6 t = -5.49 (1, 485), p = .000
Provision of assistive tech. and/or accommodations throughout rehab. process	1.85 (.73)		-.40
Consumer involvement in developing assistive tech/accommodations	1.75 (.69)		-.23
Conducting workplace assessments to identify technology needs*	1.55 (.68)		
Assisting employers in making reasonable accommodations*	1.67 (.67)		
Counselor training on assistive technology and accommodations	2.10		

**	(.72)		
Serving Those Who Have Not Been Adequately Served In The Past		.66	Admin. = 1.6, Coun. = 1.5 t = -3.93 (1, 479), p = .000
Outreach efforts to groups underserved in the past	1.85 (.69)		-.30
Efforts to address rehab. needs of individuals with HIV/AIDS	1.49 (.64)		-.10
Technical assistance to employers regarding employees with HIV/AIDS	1.32 (.54)		-.16
Provision of VR services to those with most severe disabilities first*	2.04 (.84)		

* indicates items listed on Counselor survey only

** indicates items listed on Administrator survey only

*** Administrator scores were subtracted from counselor scores

Personnel and Agency Management and Interagency Information and Services

For the purposes of this analysis, only the sections that both administrators and counselors responded to were analyzed in detail. As seen in Table 8, however, administrators were asked about agency and personnel management and interagency agreements. These two topic areas were included in the questionnaire because of changes in the amendments that mandated formal interagency agreements; participation in transition planning for students with disabilities; improvements in professional standards, training, and performance measures of rehabilitation counselors; and better serving consumers who have traditionally been under-served by increasing the number of counselors from minority backgrounds and enhancing outreach activities in the community. As in the other areas of the questionnaire, VR administrators reported only some degree of change in any of these areas (see Table 8). In the section on personnel and agency management, the greatest change was, not surprisingly, reported in "activities for informing personnel on the Rehabilitation Act Amendments." The methods used to inform staff of the changes in the law include: meetings, targeted training activities at the office and state-wide level, written materials, and communication through e-mail. According to the administrators that provided written comments on the questionnaire, most of these informational efforts focused on the 60-day eligibility and changes in language. The least amount of change was "in strategies to recruit counselors from minority communities." Many administrators who provided written comments stated that there have always been efforts to recruit counselors from minority backgrounds. Some who did report increased efforts said that this recruitment occurred through "aggressive affirmative action programs," special advertising in minority publications, active recruitment through college and university job placement offices, and job fairs. Identified roadblocks to hiring counselors from diverse backgrounds include few minority candidates with their Master's degrees, difficulty recruiting in rural areas, and hiring freezes that dampens all recruitment efforts.

When asked about how local offices implement the mandate in the Amendments to establish interagency agreements and services, most administrators reported some degree of change in this area (see Table 8). The greatest amount of reported change was in counselors taking part in transition services for students with disabilities. According to the administrators who wrote comments, this change can be traced to federal and state school-to-work initiatives and IDEA. According to these administrators, counselors are visiting schools, participating on transition teams, and are assigned specific high schools to serve transition aged youth. A few of the commenting administrators said that this has been an emphasis for many years prior to 1992. Despite the work being done by counselors on behalf of transitioning students, the least amount of change was reported in tracking the number of high school graduates each year. Reasons for the lack of change include inadequate information from the schools and LEAs (local education agencies) and that this task is done at the state level rather than the local VR office.

In addition to reporting the amount of change on agency management and interagency practices, administrators were asked to report agencies with whom VR offices have cooperative agreements. Administrators report an average of four interagency agreements. The majority of the interagency agreements listed on the questionnaire were established prior to 1992. The most common listed agency or organizations were schools and Departments of Education (n = 182). State Mental Health Agencies were the second most common agency (n = 165), followed by Mental Retardation/Developmental Disabilities agencies (n = 144), generic employment agencies and services (e.g., Departments of Employment and Training, Workman's Comp, etc.) (n = 81), and secondary education institutions (e.g., Vocational/Technical schools, community colleges, colleges and universities) (n = 20). Other agencies listed as joining VR in interagency agreements include:

- Welfare, General Assistance, Medicaid
- Departments of Health and Human Services
- Social Security
- drug and alcohol programs
- specific transition programs

- Veterans Administration
- Departments of Public Health
- Children, Youth, and Family Services
- health care centers and hospitals
- Independent Living Centers
- Departments of Corrections

The participating administrators reported a moderate amount of change in their VR agency's community exposure to broaden referral sources (see Table 8). In general, activities to accomplish this were participation in public relation events and venues such as job fairs and media presentations and holding community events to inform a wider population of consumers about VR services. The most common referral source reported by the administrators was the consumer himself or herself. Schools were the second most frequently listed referral source, followed by other major state human service agencies (mental health, mental retardation/developmental disabilities, social security, welfare, and corrections). Health care providers (e.g., doctors, therapists, and private rehabilitation professionals) were also common referral sources. Finally, word-of-mouth, friends, and parents were listed as referring consumers to VR but were not as common as those mentioned above.

Eligibility

The Amendments reduced the timeline for eligibility to 60 days with the goal of streamlining the rehabilitation process. Administrators felt there had been significantly greater change than did the counselors (see Table 8). Fifty one percent of counselors said that all 10 of their last 10 applicants were determined eligible within 60 days of application. For those who gave us information on their last 10 applicants, an average of 8.4 applicants were determined to be eligible within the 60 day limit. Likewise, out of the counselors' last 10 applicants, the average number determined ineligible was .76. Therefore, most applicants are being determined eligible for VR services within the 60 day time limit. In fact, with the mandate for a tighter timeline, 66% of administrators said that the number of cases in their office that extended beyond the 60 day eligibility time limit has decreased dramatically. The reduced eligibility timeline was intended to move consumers into services faster and thereby speed up the rehabilitation process. In comparison, data from the RSA 911 tapes indicate that the mean number of days from application to closure was 552.72 (SD = 586.29) in 1988, 524.58 (SD = 556.88) in 1993 and 545.27 (SD = 599.55) in 1995. These numbers suggest that, on average, the rehabilitation process was reduced in time quite dramatically from 1988 to 1993. Although the mean number of days from application to closure went up from 1993 to 1995, the mean is still below what it was in 1988.

The Amendments also mandated a presumption of eligibility in order to serve a wider population of individuals with disabilities, especially those with more severe disabilities. With the presumption of eligibility, the burden of demonstrating that applicants were not eligible now lies with the VR professionals. Seventy-eight percent of counselors said that none of their last 10 applicants were determined unable to benefit from rehabilitation services. When asked how this presumption has changed practice, administrators felt it was a change in mind set, a paradigm shift or a philosophical change. Counselors described more bureaucratic changes such as timeliness. Counselors also cited an increase in the number of individuals with severe disabilities on their caseloads, as was the intention of the presumption of eligibility language. Counselors reported that out of the last 10 closures, an average of 7.9 individuals were considered to have a severe disability. Forty-three percent of administrators said that since 1992 the number of applicants considered eligible for services increased somewhat. Administrators expressed concern that status 30s (unsuccessful closures) would increase if a broader population of individuals is deemed eligible for VR services (see Figure 1). Indeed, according to RSA-911 data, the percent of individuals with severe disabilities has increased over the years. In 1988, 51% of VR closures were consumers with severe disabilities. This percentage increased to 56% in 1993 and 66% in 1995.

Along with the burden of proof being placed on the VR professionals' shoulders, administrators and counselors agreed that there were more extended evaluations providing "clear and convincing evidence" that an individual would not benefit. For example, the RSA 911 data indicate that the percentage of consumers closed from an extended evaluation has hovered around two percent from 1988 to 1995 (2.1% in 1988, 1.9% in 1993 and 1.7% in 1995). These data suggest that although there may be more extended evaluations being conducted, there are fewer closures based on the outcomes of the extended evaluations alone.

Although the language in the law referring to appeals ofligibility decisions was clarified and strengthened, 93% of counselors said they have not been involved in any appeals regarding ineligibility, and 74% said that they have participated in no re-evaluations of individuals previously closed as ineligible during the past year. Indeed, according to the RSA 911 data, the proportion of individuals closed as not accepted and or not rehabilitated because their handicapping condition was too severe dropped from 7% in 1988 to 5% in 1993 to 3% in 1995. Therefore, the need for re-evaluations has dropped as well.

Use of existing information

The use of existing information where possible throughout the rehabilitation process was another streamlining effort set forth in the Amendments. Rather than conducting duplicative assessments, counselors were encouraged to use existing information to make eligibility and other decisions. According to the law, consumers have increased responsibility for providing this information. Both administrators and counselors reported that the use of existing information expedites the eligibility process and that there has been greater emphasis on the involvement of the consumer to provide existing information since 1992. Administrators felt there has been significantly greater change than did the counselors (see Table 8). Both administrators and counselors commented that the use of existing information was more cost and time effective and eliminated the need to repeat diagnostic evaluations. Counselors indicated that sometimes it can be problematic to get consumers to follow through on getting the necessary documentation. Counselors reported that an average of only five out of the last 10 applicants in their caseload provided existing information that was used in the VR process. Similarly, counselors reported having to do an average of 4.6 new assessments with clients prior to status 10, and an average of 11.6 new assessments with clients after status 10.

Consumer involvement, assessment, and the IWRP

One of the primary goals of the 1992Amendments was to increase consumer involvement in the rehabilitation process from assessment to writing and implementing the Individualized Written Rehabilitation Plan (IWRP). Both administrators and counselors described an increase in consumer involvement in the development of the IWRP and the assessment process as well as a greater emphasis on consumer choice. Administrators felt there had been significantly greater change than did the counselors (see Table 8). Administrators and counselors both reported that they encourage family members, advocates, or representatives to participate where appropriate; however, few families are actually involved in the process. Out of their last 10 closures, counselors reported only an average of 2.8 consumers had family members, advocates, or chosen representatives who participated in the IWRP. For the most part, consumers participated directly in the development of their IWRP. Counselors as a whole reported that an average of 9.5 consumers participated out of their last 10 cases closed. Indeed 85% of the counselors reported that in all 10 of their last closed cases the consumer collaborated with the counselor in determining the goals and objectives on their IWRP. Most of the IWRPs included a statement in the consumers own words as mandated by the Amendments. Out of the last 10 applicants, an average of 8.1 were reported to have had a personal statement on their IWRP. However, only 65% of the counselors surveyed said that out of their last 10 closures, all 10 IWRPs included a statement in the consumers own words describing his/her involvement.

In terms of facilitating consumer involvement in the rehabilitation process, both administrators and counselors report an increase in written materials/brochures and efforts to inform consumers about their rights under the ADA. Respondents felt that there has been an increased emphasis on consumer choice of services and the agency or vendor that will provide services. Counselors reported an average of 7.3 out of 10 consumers chose their own agency or vendor of services from at least two choices, and about half (49%) of these counselors said that all 10 of their last 10 closed consumers chose their own agency or vendor of services from at least two choices. A small percentage of counselors who provided qualitative responses indicated that they have always stressed consumer choice of service options (27%). These counselors wrote that they have always stressed consumer choice of agencies and vendors and that the Amendments did not have a big effect on this area of their practice.

The Amendments also emphasized consumer involvement in the management of the state VR system. Ongoing consumer satisfaction evaluations are one mechanism to monitor and document consumer involvement. Over a quarter (27%) of administrators said that they do not currently conduct consumer satisfaction surveys. Of those who reported that they do conduct consumer satisfaction surveys, 15% said they do so once during the rehabilitation process, 19% said they do so once a year, 9% said they do so every six months, and 31% said that consumer satisfaction surveys are administered on another schedule. Although consumer advisory boards are also required under the law, only7% of administrators reported that the consumer advisory boards affiliated with their office meet yearly, 11% said they meet once every six months, 22% said they meet once a month. Fifty-seven percent said that their consumer advisory boards meet on another schedule, which was not specified. Twenty-five percent did not answer. (Note: These item-by-item percentages and do not sum to 100.)

Integrated service settings and job placements are emphasized in the Amendments. Both administrators and counselors described more opportunities for individuals in integrated environments since 1992, and that the availability of job coaches has increased the use of integrated employment opportunities. Counselors reported that out of the last 10 status 26 closures, an average of 8.8 consumers found integrated employment. Fifty-nine percent of counselors said that out of their last 10 successfully rehabilitated closures (26), all 10 consumers found integrated employment. Indeed, competitive closures have increased since 1993. According to RSA 911 data, in both 1988 and 1993 82% of successful closures were competitive. In 1995, the competitive closure rate increased to 86%. The data from the RSA 911 tapes indicates that of all successful closures there are still considerably more competitive employment closures than there are sheltered employment closures as has been the case since before the 1992 Amendments. It is encouraging to note that in 1995 the percent of sheltered employment closures has decreased by one-third since 1988 (6% in 1988, 5% in 1993 and 4% in 1995).

Assistive technology and accommodations

Assistive technology and accommodations are referenced in the Amendments as rehabilitation technology services. Examples of technology services include a whole range of high and low tech devices that assist individuals in their daily lives such as wheelchairs, computer devices and software, reachers, and prosthetics. Accommodations include strategies or devices that allow an individual with some limitation to participate more fully in his or her job placement, services, or the rehabilitation process itself. Examples include conducting business in a language other than English, using communication support or devices and restructuring schedules or job descriptions. It was the intent of the Amendments that Rehabilitation Technology services be used throughout the rehabilitation process. In addition, the changes in the law mandate that consumers be actively involved in the design and implementation of their rehabilitation technology.

According to the findings, both administrators and counselors felt the consumer was actively involved in developing assistive technology accommodations, although the reported rate of using assistive technology and accommodations was low. Administrators felt there has been significantly greater change than did the counselors (see Table 8). Counselors reported that out of their last 10 closures, an average of 1.9 out of 10 consumers received assistive technology as part of their VR services, and an average of 2.7 out of 10 consumers received accommodations as part of their VR services. Workplace assessments were rarely carried out and counselors reported that out of their last 10 closures, an average of one work place assessment was conducted and only an average of one client needed VR assistance to help an employer make reasonable accommodations. Despite these low numbers, however, administrators and counselors do see an increased use of assistive technology and accommodations and attribute this change to the increased existence of such technology and an increase in specially trained staff.

Serving those who have not been adequately served in the past

One of the central goals of the 1992 Amendments was to expand the use of VR services to all eligible individuals. The law mandated that VR agencies work to better serve populations of individuals with disabilities who have not been adequately served in the past. This means that outreach efforts were needed to target ethnic and culturally diverse groups, individuals with severe disabilities who have in the past been considered unable to benefit from VR services, and those with diagnoses (such as HIV and AIDS) that are now understood to have an impact on work and worklife. Both administrators and counselors thought the least amount of change occurred in this area, although administrators felt there had been significantly greater change than did the counselors (see Table 8). Nevertheless, administrators and counselors agreed that increased efforts and plans to target underserved groups are under development. For example, both groups described an increased awareness and a focus on training around the needs of individuals with HIV, but only 33% of the counselors reported that they were aware of any consumers on their caseloads being HIV positive or having AIDS.

In general, respondents saw the greatest increase in services to the following cultural groups: Latin-American, Asian, and Native American. Both administrators and counselors described an attempt at increasing the capacity to assess and plan in the consumers' native language through staff training in cultural diversity and the hiring of bi-lingual staff. According to the respondents, however, the need for providing services in native language of the consumer other than English is rare. Indeed, 85% of counselors had no one in their last ten closures who needed information in a language other than English. Administrators reported a mean of 26 people currently served in their office who would benefit from the use of a language other than English.

According to the counselors, the greatest change can be seen in the numbers of individuals with severe disabilities now being served with greater success. According to the RSA 911 data tapes, in 1988, 64% of those who were successfully rehabilitated (status 26) had a designation of severe disability. This percentage increased in 1993 (72%) and increased again in 1995 to a successful rehabilitation rate of 76% for individuals successfully rehabilitated with severe disabilities. In order to understand something about the nature and extent of the disabilities of the consumers being served respondents were asked if their consumers used or needed materials and services in adapted formats. In response to this, 95% of counselors said that of their last 10 closures, no one needed materials produced in an adapted format (augmentative communication systems, picture boards, etc.). Likewise, administrators reported a median of only 5 people currently served in their office who would benefit from the use of alternative modes of communication. It is unclear as to how states are prioritizing the service needs of potential consumers with the most severe disabilities. Although each state is required by law to specify a plan to serve these individuals first, only 64% of administrators indicated that they currently have an order of selection process in place.

Correlation of Change Characteristics to Practice Areas

As discussed above, counselors and administrators were asked to report whether or not they perceived changes in the clients with whom they work and the people served in their offices. The following four areas were addressed and defined as severity of disability, cultural or ethnic diversity, the number of people rehabilitated, and the number of people not rehabilitated. These areas can be thought of as consumer characteristics (severity of disability and ethnic and cultural diversity) and rehabilitation outcomes (numbers of people rehabilitated and not rehabilitated). As a way of further understanding the nature of changes in VR practice, comparisons were made between those who reported observing change in these four areas and those who did not report change. The results of this analysis can be seen in Table 9. In general, the findings indicate that those who observed differences in severity of disability, cultural diversity, and the number of successful rehabilitation closures among the people with whom they work also reported significantly greater change in VR practices as measured by responses on the five-point change item subscales. For the most part, changes in the number of unsuccessful rehabilitation closures were not related to perceptions of changes in VR practices. The one exception to this can be found in the relationship between changes in numbers of unsuccessful rehabilitations and responses to the eligibility subsection of the questionnaire. Although the direction of these relationships cannot be attributed, it seems that offices and counselors who are working with a changing consumer base are more likely to note changes in their practice. As noted earlier, however, the number of successful rehabilitation closures nationally is going down. Therefore, changes in successful closures observed by the administrators and counselors are in a negative direction. This suggests that goals of expanding the diversity of the VR consumer population and changing practices to streamline the rehabilitation process have not necessarily led to the positive employment outcomes.

Table 9

Significant Differences* in Practice Areas Reported by those who Observed Change Characteristics

Change Characteristics	Observed change	Standard Deviation	$t_{(df)}$
Changes in Eligibility Practice			
Severity of disability	no: 1.55	.45	$t=-5.15_{(1, 452)}$

	yes: 1.80	.48	
Cultural/ethnic diversity	no: 1.67	.48	$t=-3.89_{(1, 415)}$
	yes: 1.90	.48	
Number of people rehabilitated	no: 1.65	.46	$t=-2.78_{(1, 415)}$
	yes: 1.78	.48	
Number of people not rehabilitated	no: 1.63	.47	$t=-3.96_{(1, 379)}$
	yes: 1.83	.48	
Changes in Use of Existing Information			
Severity of disability			
Cultural/ethnic diversity	no: 1.94	.61	$t=-3.39_{(1, 419)}$
	yes: 2.20	.58	
Number of people rehabilitated	no: 1.90	.58	$t=-2.71_{(1, 415)}$
	yes: 2.07	.62	
Number of people not rehabilitated			
Changes in Consumer Involvement			
Severity of disability	no: 1.55	.48	$t=-3.83_{(1, 452)}$
	yes: 1.73	.45	
Cultural/ethnic diversity	no: 1.61	.45	$t=-5.31_{(1, 419)}$
	yes: 1.91	.44	
Number of people rehabilitated	no: 1.57	.40	$t=-4.18_{(1, 414)}$
	yes: 1.75	.50	
Number of people not rehabilitated			
Changes in Assistive Technology/Accommodations			

Severity of disability	no: 1.69	.61	$t=-2.43_{(1, 450)}$
	yes: 1.85	.63	
Cultural/ethnic diversity	no: 1.74	.62	$t=-3.33_{(1, 417)}$
	yes: 2.01	.65	
Number of people rehabilitated	no: 1.71	.60	$t=-2.53_{(1, 413)}$
	yes: 1.87	.65	
Number of people not rehabilitated			
Changes in Serving Those Previously Underserved			
Severity of disability			
Cultural/ethnic diversity	no: 1.52	.49	$t=-3.79_{(1, 413)}$
	yes: 1.75	.51	
Number of people rehabilitated	no: 1.46	.46	$t=-3.55_{(1, 404)}$
	yes: 1.63	.52	
Number of people not rehabilitated			

Note. All reported t-test results are significant beyond at least .05 level. 0=perception that no change occurred for that change characteristic. 1=perception that change occurred for that change characteristic.

ICI
INSTITUTE FOR COMMUNITY INCLUSION

Chapter 4

Discussion and Implications

A national survey of Vocational Rehabilitation local office administrators and counselors was conducted to identify critical elements of the 1992 Rehabilitation Act Amendments and the impact of the law on changing practice. Participants were asked to rate the extent of change they observe in their office or caseload since the Amendments in terms of consumer variables, rehabilitation outcomes, and daily practice. Comparisons were made between administrators and counselors and between those that observed changes in consumer variables and rehabilitation outcomes and those that did not. This section will present a summary of major findings, implications for practice, and suggestions for future research.

Summary of Findings

In general, administrators indicated they perceived significantly more change than did counselors when asked whether or not the 1992 Rehabilitation Act Amendments have had an impact on daily practice. However, neither group felt that more than "some change" had occurred in their offices or on their caseloads.

Through a factor analysis of the change items common to both the counselor and administrator questionnaire, three internally consistent factors were identified. These were (1) Consumer Choice/Awareness, (2) Consumer Advocacy, and (3) AIDS Knowledge. Both counselors and administrators perceived the least amount of change occurring in the AIDS Knowledge area. Although neither group perceived that a great deal of change had occurred in any of the three areas, administrators perceived the greatest change in Consumer Choice and Advocacy. The greatest disparity in the perceptions of administrator and counselors was in the area of Consumer Advocacy.

A large percentage of both administrators and counselors perceived change in the severity of disability of individuals served. These results make it clear that more individuals with severe disabilities have been determined eligible in the vocational rehabilitation system. However, only a small percentage of both administrators and counselors perceived change in the cultural or ethnic diversity in their offices or on their caseloads. Increases in status 26 closures (successful rehabs) were noted by both groups, yet the two groups agreed that due primarily to the increase in efforts to serve the most severely disabled population and the 60 day eligibility determination, there was also an increase in the number of individuals not rehabilitated (status 28, 30).

In addition to the perceptions of change across the four change characteristics described above (severity of disability, cultural or ethnic diversity, the number of people rehabilitated and the number of people not rehabilitated), the research instrument was designed and organized to cover five topic areas as noted in the 1992 Amendments: eligibility, use of existing information, consumer involvement, assistive technology and accommodations and serving those who have been underserved in the past. Across all of these content areas, administrators perceived that greater change had occurred than did counselors. The findings suggest that most applicants are being determined eligible within the 60 day time limit and that the mandated presumption of eligibility is being upheld in practice. This is evident in that 75% of counselors reported that none of their last 10 applicants were determined unable to benefit from rehabilitation services. Counselors also cite an increase in the number of individuals with severe disabilities on their caseloads, as was the intention of the presumption of eligibility language.

Concerning the use of existing information, both administrators and counselors reported that there has been an increased emphasis on the use of existing information. Both groups of respondents thought the most change occurred in the use of existing information over all other practice areas.

In addition to these two practices areas, both administrators and counselors described both an increase in consumer involvement in the development of the IWRP and the assessment process as well as a greater emphasis on consumer choice. Counselors as a whole reported an average of 9.5 consumers participated in the IWRP development out of their last 10 cases closed. Indeed, 85% of the counselors said all 10 of their last closed cases collaborated (with the counselor) in determining the goals and objectives of the IWRP. In addition, administrators and counselors report an increase in written materials/brochures and efforts to inform individuals of their rights under ADA and an increased emphasis on consumer choice of their own agency or vendor of services. However, also noteworthy is the relatively low percentage of both administrators and counselors that reported an emphasis of consumer involvement in the management of the state VR system. Finally, both administrators and counselors described the existence of more opportunities for individuals in integrated environments since the 1992 Rehabilitation Act Amendments and that the availability of job coaches has increased the use of integrated employment options.

Both administrators and counselors felt that the consumer was also actively involved in developing assistive technology accommodations, although the rate of using assistive technology was reportedly low in the survey. Despite the low numbers, administrators and counselors do see an increased use of assistive technology and accommodations, and attribute this change to the advancement of such technology and an increase in specially trained staff. The use of assistive technology may be more wide spread if staff capacities and expertise were increased beyond those with special training and responsibility. Counselors also described the existence of more resources to assist them in assessing need and providing assistance related to assistive technology to their clients.

The final practice area of the 1992 Rehabilitation Act Amendments is the mandate to serve individuals that have not been adequately served in the past. Administrators and counselors did agree that increased efforts and plans to target underserved groups are under development but have not been fully instituted. The increase in numbers of people with severe disabilities suggests that individuals with severe disabilities, who may have previously been judged ineligible, have gained greater access to the vocational rehabilitation system. Both groups described an increased awareness and a focus on training around the needs of individuals with HIV, but only 33% of the counselors reported that they were aware of consumers on their caseloads as actually being HIV positive or having AIDS. In general, respondents saw the greatest increase in services to Latin-American, Asian and Native American cultural groups. Both administrators and counselors described an attempt at increasing the capacity to assess and plan in the consumer's native language through staff training in cultural diversity and the hiring of bi-lingual staff. However, they continue to see the need for this as low. The relatively low percentage of both counselors and administrators that perceived change in the racial or ethnic background of their clients indicates that although the 1992 Rehabilitation Act Amendments encouraged VR agencies to extend outreach efforts to culturally and ethnically diverse communities, the desired goal is only beginning to be achieved.

Implications for Practice

As the results of the study indicate, the changes in VR practice since the implementation of the 1992 Amendments have not been drastic. It is clear that the major goals of the Amendments, while being addressed, have not been fully met. One must keep in mind, however, that regulations for implementation of the Amendments were not in place until the winter of 1997. The following discussion addresses issues of differences in perception and critical elements of the law such as access, consumer involvement, improved services, and over all perspectives on change.

Differences in Perception

Although some change has been observed byboth administrators and counselors, these two groups perceive this change differently. The fact that counselors feel there has been less change in daily practice than do the administrators suggests organizational issues that should be addressed. Perhaps greater communication between levels of the organization, even at local level, should be a priority for the future. Certainly, the Amendments came with high expectations of change for VR practice and these expectations, no doubt, influence perceptions. Nevertheless, enhanced communication and ongoing evaluation of practice can serve to clarify the nature of practice.

Systemic change is not a one-time event but rather a series of incremental steps leading to a new approach, design or way of providing services. The sweeping changes of the Rehabilitation Act Amendments of 1992 were apparent. What was not and is seldom apparent is the impact of such a significant change in actual practice, in this case the delivery of rehabilitation services to persons with severe disabilities. While one would like to see systemic change occur in a more rapid fashion, in reality, change will occur over a protracted period of time, especially for a major system such as the Vocational Rehabilitation system which has been in operation for almost eight decades. What we have found in this study is that while the process for change has been set in motion, not all the participants view the process in the same way. For the administrators a greater degree of change is here already while the counselors feel that the change process has not moved very far.

The results of this study document that change is occurring but that the pace of change is modest. For the administrators, the perception of the amount of change seems to exceed the reality of change as reported by the practitioners, the front line rehabilitation counselors. Some of the areas where an emphasis on training was placed, as in the care of the length of time for eligibility determination, have shown that change can happen. The more global issues or areas of change, such as increased involvement of consumers and the involvement of the family and significant others, has not happened to any great extent. Other studies have shown that with the active involvement of the individual and the utilization of personal networks there is a shorter time to placement, more effective entry into jobs of choice, and greater earnings for the consumer (Temelini & Fesko, 1996). Incorporating strategies of network development and more aggressive involvement of the consumer in the entire rehabilitation process will lead to improved employment outcomes for all consumers.

Access

Attempts to streamline the rehabilitation process have resulted in increased access for some consumers since a greater number of individuals are being accepted for services. Nevertheless, the number of individuals from diverse backgrounds is growing slowly. African Americans, those of Hispanic origin, Asian Americans, and Native Americans still remain under-served by the state Vocational Rehabilitation system. There has also been a slow change in the number of days in the rehabilitation process. The average length of time from application to closure has decreased by about seven days over a seven year period (1988 to 1995). Unfortunately, as access increases a greater number of people are being closed as unsuccessfully rehabilitated. From a policy perspective, if the intent was to increase the rate of access and reduce the waiting time for entry, then there appears to be some support for this. If however, the intent is to either shorten the length of time for an individual to enter employment or to increase the number of people who will be employed, changes in the length of time for eligibility determination would seem to have had little impact.

While there is greater access for persons with severe disabilities, the true outcome is real work not eligibility for services that either lead to an unsuccessful closure or closure in a setting that is not wanted by the individual. Attempts to streamline the rehabilitation process have resulted in increased access since a greater number of individuals are being accepted for services. The increased number of closed not rehabilitated as well as the minimal change in the number of persons closed after extended evaluation would support the need for a more concerted effort at enhancing the capacity of the public rehabilitation system to increase the employment of this previously "not eligible" population.

Funding is, of course, a concern as it is in any human service system. This, however, is not the only remedy for addressing the increasingly complex needs of a growing consumer base. In addition, more training is needed in job and career development as well as supporting individuals with severe disabilities on the job. There is a need to expand the capacities of service providers with whom VR contracts to support individuals with severe disabilities in individual jobs in their communities in fields that match their vocational goals and dream. Training is needed in the areas of natural supports, personal network building, as well as assistive technology devices and services to facilitate the job search process and the likelihood of job retention. These strategies are useful not only for those with severe disabilities but also for any one with any type or level of disability as they enter or re-enter the work force.

There is also a need to expand the capacity of the community rehabilitation provider and the other contract resources that VR uses. More creative and supportive designs should be used to assist persons with severe disabilities in identifying interests, developing rehabilitation plans, implementing such plans, accessing jobs and advancing in employment. The Rehabilitation Act Amendments of 1992 call for innovation and a different way of supporting persons with severe disabilities in the search and access of real jobs.

Addressing the needs of consumers from diverse cultural backgrounds present additional challenges in crafting support systems. This challenge is complicated by the current staff configuration of the public rehabilitation system. With only 5% of the respondents to the survey from African American cultures and 4% from the Latino community, this does not represent a picture of culturally friendly services. The increased challenge in recruiting and hiring rehabilitation professionals from these communities has been identified as a priority. The preservice training programs supported by RSA are being required to respond to this need. The hiring practices at the local level must be expanded to reflect a more aggressive outreach to these communities when positions are available. Active outreach and linkages to culturally diverse community agencies as service providers may also serve to change the perception of the public rehabilitation system as one that does not embrace the needs of persons with disabilities from linguistically and culturally diverse communities.

Consumer Involvement

Consumer advisory roles have been clarified in the law and practice. Nevertheless, in order to insure that consumer involvement is maintained and maximized during the rehabilitation process, involvement should be monitored throughout the rehabilitation process. Although RSA 911 data helps us understand closure or outcome variables, it does not document or clarify process issues such as the use of existing documentation, consumer involvement, choice, and the use of assistive technology to facilitate the rehabilitation process. Other means of tracking these issues should be developed. Exit interviews with consumers could accomplish the task of better understanding the ways in which consumers were involved in the rehabilitation process, choices that were offered, and decisions made. On-going evaluation of consumer involvement can document where genuine involvement and consumer direction is occurring and identify where it is lacking. This on-going evaluation of process variables must be conducted or summarized on a national level in order to understand the system as a whole. Local VR offices should not stop, however, at the documentation of successes and weaknesses. Rather, there should be action plans developed and monitored to insure continuous improvement in the level of consumer involvement that takes place.

Improved Services

The task of monitoring improvement in services in the future should be accomplished through further definition of these services and resulting outcomes within the VR system. Greater use of supported employment, on-the-job-training, personal assistance services, and a wider range of rehabilitation technology need to be documented. The creative use of all of these services can and should lead to greater numbers of successful rehabilitation outcomes for individuals with severe disabilities. Tracking the relationships between these services and rehabilitation outcomes would be more straight forward with the further refinement of the status 26 code, which would clarify the nature of the successful employment outcome. Rehabilitation technology is one example of the need to improve services by expanding the knowledge base of counselors and consumers on the full range of high and low tech options and to increase consumer empowerment and involvement in the design of the appropriate technology and accommodations.

Suggestions for Future Research

Consumer Perspectives

The current research examined only administrators and counselor perspectives of changes in the state rehabilitation system. The findings of the current research are limited in as much as the consumer voice is silent. In order to complete the assessment of change and the effects of the law on the lives of people with disabilities, consumers of vocational rehabilitation services must be taken into consideration. This needs to be a focus for future research both as a mechanism of program evaluation within the state rehabilitation systems and from the position of external, independent evaluation as well. A truly multi-stakeholder approach to analyzing a service delivery system must include the consumers of those services.

Ongoing Assessment

The current study lays the groundwork for an independent, external evaluation of state Vocational Rehabilitation services. Future research must now establish ongoing assessments of the service delivery system in order to continually evaluate issues of access, consumer involvement, and quality practices. Ideally, this evaluation would be conducted in collaboration with the Vocational Rehabilitation system, take a multi-stakeholder approach, and evaluate both process and outcome variables (Schalock, 1994).

Baseline Data

Over the period that the current research was being conducted, much talk of restructuring vocational services was taking place at a national level. With the opening of the One-Stop Career Centers, the intent to house all services related to finding, acquiring, and maintaining work under one roof, has moved forward. Furthermore, welfare reform has placed additional pressures on the delivery of vocational services. While these issues are primarily discussed in terms of designing services for individuals without identified disabilities, the climate of change and emphasis on return-to-work certainly should include discussions of the impact on individuals with disabilities. The current study provides baseline information to consider as changes and re-organization takes place the Vocational Rehabilitation services. In order for this to happen, future research should continue to examine issues such as access, consumer involvement, assistive technology, serving under-served populations, and others as practices change over time.

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

References

Apter, D. S., (1994). From dream to reality: A participant's view of the implementation of Part H of P.L. 99-457. Journal of Early Intervention, 18, 131-140.

Bertrand, J.T., Brown J.E., & Ward, V.M. (1992). Techniques for analyzing focus groups data. Evaluation Review, 16, 198-209.

Blanck, P. D. (1995). Assessing five years of employment integration and economic opportunity under the Americans with Disabilities Act. Mental and Physical Disability Law Reporter, 19, 384-392.

Bowman, O. J., & Marzouk, D. K. (1992). Implementing the American with Disabilities Act of 1990 in higher education. American Journal of Occupational Therapy, 46, 521-533.

Brown, S., & Johnson, K. (1994). Recent federal legislation and the role of vocational rehabilitation in the transition from school to community. Rehabilitation Education, 8(1), 67-78.

Campbell, J. (1991). The consumer movement and implications for vocational rehabilitation practice. Journal of Vocational Rehabilitation, 1(3), 67-75.

Curl, R., & Sheldon, J. (1992). Achieving reasonable choices: Balancing the rights and responsibilities of consumers with those of rehabilitation counselors. Rehabilitation Education, 6, 195-205.

DeVellis, R.F.(1991). Scale development: Theory and applications. Newbury Park, CA: Sage.

Feist-Price, S. (1995). African Americans with disabilities and equity in vocational rehabilitation services: One state's review. Rehabilitation Counseling Bulletin, 39(2), 119-129.

Fink, A., & Kosekoff, J.B. (1985). How to conduct surveys: A step by step guide. Newbury Park, CA: Sage.

Goodall, P., Lawyer, H., & Wehman, P. (1994). Vocational rehabilitation and traumatic brain injury: A Legislative and public policy perspective. Journal of Head Trauma Rehabilitation, 9(2), 61-81.

Griffin, C. (1994). Improving rehabilitation service utilization among ethnic/racial groups: Rehabilitation administrator's role. Journal of Rehabilitation Administration, 18(1), 37-43.

Guy, B., Merrill, P., & Johnson, D.R. (1993). IDEA and Rehabilitation Act Amendments: Impact on employment IMPACT, 6(3), 14-19.

Harp, H.T. (1994). Empowerment of mental health consumers in vocational rehabilitation. Psychosocial Rehabilitation Journal, 17(3), 83-89.

Jarret, R.J. (1975). Focus group interviewing with low-income minority populations: A research experience. In Morgan, D.L. (Ed.), Successful focus groups: Advancing the state of the art, (pp. 184-201). Newbury Park, CA: Sage.

Knodel, J. (1993). The design and analysis of focus group studies: A practical approach. In Morgan, D.L. (Ed.), Successful focus groups: Advancing the state of the art. (pp. 35-50). Newbury Park, CA: Sage.

Leuchovius, D., & Parker, R. (1994, September). The Rehabilitation Act and the ADA Connection. The Pacesetter, 18-19.

Klimoski, R., & Palmer, S. (1993). The ADA and the hiring process in organizations. Consulting Psychology Journal, 34(2), 10-36.

National Council on Disability (1995). The Americans with Disabilities Act: Ensuring equal access to the American dream. Washington, DC: Author.

National Council on Disability (1996). Improving the implementation of the Individuals with Disabilities Education Act: Making schools work for all of America's children. Washington, DC: Author.

O'Brien, J., & Lovett, H. (1993). Finding a way toward everyday lives: The contribution of person centered planning, Harrisburg, PA: Pennsylvania Office of Mental Retardation.

Pati, G. C., & Bailey, E. K. (1995). Empowering people with disabilities: Strategy and human resource issues in implementing the ADA. Organizational Dynamics, 23(3), 52-69.

Pedhazur, E. & Schmelkin, L.P. (1991). Measurement, design, and analysis: An integrated approach. Hillsdale, NJ: Lawrence Erlbaum.

RehabACTion Advocacy Network (1992, October). Congress extends Rehabilitation Act for five years: Major emphasis set on placement in competitive employment, In the Public Interest, 1(6), 1-13.

Rehabilitation Act Amendments of 1992, 29 U.S.C.A. sec.123a (West Supp. 1993).

Rehabilitation Services Administration (1990). RSA911 Caseload statistics FY 88. Department Of Education, Office of Special Education and Rehabilitation Services. Washington, DC: Author.

Rehabilitation Services Administration (1995). RSA911 Caseload statistics FY 93. Department Of Education, Office of Special Education and Rehabilitation Services. Washington, DC: Author.

Rehabilitation Services Administration (1997). RSA911 Caseload statistics FY 97. Department Of Education, Office of Special Education and Rehabilitation Services. Washington, DC: Author.

Rehabilitation Services Administration (l997). Annual report to the President and to the Congress: Fiscal Year 1994. Washington, DC: Author.

Schalock, R.L. (1994). Quality of life, quality enhancement, and quality assurance: Implications for program planning and evaluation in the field of mental retardation and developmental disabilities. Evaluation and Program Planning, 17, 121-131.

Schriner, K. F. (1995). Implementing IDEA: IEP meetings in demonstration and non-demonstration sites in a rural systems change state. Rural Special Education Quarterly, 14(3), 36-42.

Shreve, M., (1994). The Greater Vision: an advocate's reflections on the Rehabilitation Act Amendments of 1992 American Rehabilitation, 60(2), 8-13.

Snook, S. & Gorsuch, R.L. (1989). Component analysis versus common factor analysis: A Monte-Carlo study. Psychological Bulletin, 106, 148-154.

Temelini, D. & Fesko, S. L. (June, 1996). Shared responsibility: Job search practices from the consumer and staff perspective. (Research to Practice) Boston: Institute for Community Inclusion (UAP), Children's Hospital.

Thomas, D., & Whitney-Thomas, J. (1996). Perspectives from consumers and counselors on elements that influence vocational rehabilitation service delivery (Research to Practice) Boston: Institute for Community Inclusion (UAP), Children's Hospital.

Weber, M.C., (1994). Towards access, accountability, procedural regularity and participation: The Rehabilitation Act Amendments of 1992 and 1993 Journal of Rehabilitation, 21-25.

Wenkart, R. D. (1995, April). The Americans with Disabilities Act and its impact on public education. Reston, VA: National Association of Secondary School Principals.

West, M. (1995). Choice, self-determination and vocational rehabilitation services: systemic barriers for consumers with severe disabilities. Journal of Vocational Rehabilitation, 5, 281-290.

Whitney-Thomas, J., & Thomas D. M.(1996). Multiple perspectives on implementing the Rehabilitation Act Amendments of 1992 (Research to Practice) Boston: Institute for Community Inclusion (UAP), Children's Hospital.

Whitney-Thomas, J. &Thomas D. (1996). Changes in vocational rehabilitation practice in 1992: Administrators' and Counselors' perspectives (Research to Practice) Boston: Institute for Community Inclusion (UAP), Children's Hospital.

INSTITUTE FOR
COMMUNITY
INCLUSION

Appendix A

Administrator Survey Instrument

VR Administrator
Respondent Information

Your answers to the questions in this section will help us better understand our respondents.

1. Your Job Title: ______________________ 2. When did you begin your current job? ______/______ (Month / Year)

3. What is your racial/ethnic background?

______ White Are you of Hispanic Origin?: Yes___ No___
______ Black
______ American Indian/Alaskan Native
______ Asian/Pacific Islander

4. What is your gender? Male ______ Female ____

5. How would you classify the geographic environment served by the office where you work? (Check one)

Urban/Suburban _____ Rural ______ Both ______

6. Have the people served or status code trends changed in the office where you work since 1992? (Circle one)

a. Severity of disability Yes No Don't Know If yes, how ______________________
b. Cultural or ethnic diversity Yes No Don't Know If yes, how ______________________
c. Number of people closed "rehabilitated" (status 26) in a year Yes No Don't Know If yes, how ______________________
d. Number of people closed "not rehabilitated" (status 28, 30) in a year Yes No Don't Know If yes, how ______________________
e. Other changes observed in the office where you work (Please list):

Critical Aspects of the 1992 Rehabilitation Act Amendments

The items in this questionnaire reflect practices highlighted in the 1992 Rehabilitation Act Amendments. **Please respond to these items as they relate to practices in the VR office where you work.** Please also provide as much descriptive information as you can about how these changes are being/have been addressed in your office. Feel free to attach additional pages if necessary.

The rating scale measures the extent to which the implementation of the following practices **has changed in your office** since the 1992 Rehabilitation Act Amendments. Please circle the number that best describes the amount of **change** that has taken place in your office in relation to each practice.

1 = No change **2 = Some change** **3 = A great deal of change**

Personnel and Agency Management: *The 1992 Rehabilitation Act Amendments offer guidelines for policies that govern the delivery of VR services throughout the country. Items 1-5 relate to the planning and implementation of procedures and policies related to the 1992 Amendments.*

		Change (Circle One)	**How, specifically, has this practice changed?**
1.	Activities for informing personnel in your office on the Rehabilitation Act Amendments.	1 2 3	
2.	State wide professional standards for counselors and other rehabilitation professionals.	1 2 3	
3.	Opportunities for counselor training and professional development.	1 2 3	
4.	A system for evaluating counselor performance.	1 2 3	
5.	Strategies to recruit counselors from minority communities.	1 2 3	

Interagency Information and Services: *The Rehabilitation Act Amendments encourage VR agencies to establish formal relationships and working groups with agencies such as The Department of Mental Health, Department of Mental Retardation/Developmental Disabilities, Public Schools, Welfare, etc. in order to facilitate service delivery. Items 6-12 are related to procedures regarding information, services, and relationships shared with agencies and the* ***VR office where you work****.*

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	**How, specifically, has this practice changed?**
6.	Interagency working groups or formal agreements between your VR office and other agencies (e.g., Department of Mental Health, Department of Mental Retardation/Developmental Disabilities, Public Schools, etc.) to facilitate service delivery.	1 2 3	
7.	Counselors' participation in the transition of students from educational service delivery into VR.	1 2 3	
8.	Procedures to encourage eligible young adults who were not part of the special education service system to access VR services.	1 2 3	
9.	Tracking the number of students who are expected to graduate from high school each year.	1 2 3	
10.	Agency's exposure in the community in order to broaden the range of referral sources.	1 2 3	

Additional Items about Interagency Information and Services

11. Please list the five most frequent referral sources (e.g., schools, parents, consumer, MR/DD agency, etc.) of consumers to the agency in which you work.

____________	____________	____________	____________	____________
1 **Most Frequent**	2	3	4	5 **Least Frequent**

12. Please list agencies that have a written agreement or working group with your VR office (e.g., Department of Mental Health, Department of Mental Retardation/Developmental Disabilities, Public Schools, etc.) to facilitate service delivery.

Agency in cooperative agreement or working group with VR	established before 1992	established since 1992
______________________________	☐	☐
______________________________	☐	☐
______________________________	☐	☐
______________________________	☐	☐
______________________________	☐	☐

***Eligibility**: The 1992 Amendments reduced the maximum amount of time for an eligibility decision to sixty-days. Items 13-20 pertain to the process by which applicants' eligibility is determined and the implications of ineligibility.*

1 = No change 2 = Some change 3 = A great deal of change

		Change (Circle One)	How, specifically, has this practice changed?
13.	Methods for monitoring cases that extend beyond the sixty-day limit.	1 2 3	
14.	The presumption that applicants will be able to benefit from rehabilitation services.	1 2 3	

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	How, specifically, has this practice changed?
15.	Methods to document and demonstrate the judgment that an individual would not benefit from VR services.	1 2 3	
16.	Yearly re-evaluation of individuals who are determined ineligible because they are considered unable to benefit from VR services.	1 2 3	
17.	Formal process by which consumers appeal a decision of ineligibility.	1 2 3	

Additional items about Eligibility

18. Since 1992, the number of cases in your office that extend beyond the limit for an eligibility decision has (circle one):

Decreased dramatically	Decreased somewhat	Stayed the same	Increased somewhat	Increased dramatically
1	2	3	4	5

19. Since 1992, the number of applicants considered eligible for services has (circle one):

Decreased dramatically	Decreased somewhat	Stayed the same	Increased somewhat	Increased dramatically
1	2	3	4	5

20. Please indicate the extent to which you agree with the following statements:

1 = disagree strongly , 2 = disagree somewhat, 3 = neutral, 4 = agree somewhat, 5 = agree strongly

		Circle One
a.	Sixty day eligibility has significantly streamlined the VR process.	**1 2 3 4 5**
b.	Sixty day eligibility has effectively reduced the VR bureaucracy.	**1 2 3 4 5**
c.	The sixty day eligibility period has effectively reduced the amount of time it takes a consumer to move from applicant status into services.	**1 2 3 4 5**
d.	Sixty day eligibility allows enough time for a counselor to make an informed decision.	**1 2 3 4 5**
e.	Service plans are developed sooner due to the sixty day eligibility period.	**1 2 3 4 5**
f.	Sixty day eligibility allows enough time for counselors to conduct comprehensive assessments.	**1 2 3 4 5**
g.	More hours of the work week are spent making eligibility decisions about applicants than before 1992.	**1 2 3 4 5**
h.	The consumers who are served in your office are satisfied with the sixty-day eligibility period.	**1 2 3 4 5**

You've completed approximately half of the questionnaire! Let us take this opportunity to thank you for your thought and effort!
Keep going!

Use of Existing Information: *The 1992 Amendments encourage VR agencies to use existing information where possible throughout the rehabilitation process. This existing information can be diagnostic information from a physician or psychologist, standardized assessment, or any documentation that contributes to the eligibility decision or the rehabilitation process. Items 21-23 are related to the use of client's previous information in records in the rehabilitation process.*

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	How, specifically, has this practice changed?
21.	Use of existing information from other sources through the rehabilitation process (e.g., diagnostic information, standardized assessments, etc.)	1 2 3	
22.	Consumers' responsibility for providing the VR counselors with existing information through the rehabilitation process.	1 2 3	

Additional Items about the Use of Existing Information

23. Please indicate the extent to which you agree with the following statements about the use of existing information:

1 = disagree definitely, 2 = disagree somewhat, 3 = neutral, 4 = agree somewhat, 5 = agree definitely

		Circle One
a.	Existing information is generally adequate for the purposes of making eligibility decisions.	1 2 3 4 5
b.	The use of existing information has reduced paperwork delays during the eligibility decision process.	1 2 3 4 5
c.	The VR assessment process is easier with the use of existing information.	1 2 3 4 5
d.	The use of existing information creates a cost savings for my VR office.	1 2 3 4 5

Consumer Involvement, Assessment, and the IWRP: *The Amendments emphasize consumer involvement throughout the rehabilitation process. Items 24-41 address the active involvement of the consumers as they are served by your office and the process by which appropriate services are identified in the IWRP.*

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	How, specifically, has this practice changed?
24.	Assessment of the consumer's needs, skills, and vocational goals after eligibility has been determined.	1 2 3	
25.	Active consumer involvement in the development of the IWRP.	1 2 3	
26.	Active involvement of family members, advocates, or a representative of the consumer in the IWRP development when necessary.	1 2 3	
27.	Conducting assessment and planning in the native language of the individual with disabilities.	1 2 3	
28.	Use of alternative formats (e.g., Braille or enlarged print) when needed in assessment and planning.	1 2 3	
29.	Assessment of consumer satisfaction and necessary changes in service delivery.	1 2 3	

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	How, specifically, has this practice changed?
30.	Activities for informing consumers of their rights under the Rehabilitation Act Amendments.	1 2 3	
31.	Activities for informing consumers of their rights under the Americans with Disabilities Act.	1 2 3	
32.	Consumer advisory board's role in the implementation of the Rehabilitation Act Amendments.	1 2 3	
33.	Client Assistance Programs to help consumers with advocacy, legal and administrative advise, facilitate access to services, and/or issues that directly relate to employment.	1 2 3	
34.	Strategies to make consumers aware of options and the choices of services available to them.	1 2 3	
35.	Consumer choice of the agency or vendor that will provide services.	1 2 3	
36.	Placements opportunities for individuals in integrated environments.	1 2 3	

Additional Items about Consumer Involvement, Assessment, and the IWRP

37. What is the frequency that consumer satisfaction surveys are administered by your office? (Circle)

Do not currently conduct	Once during the rehabilitation process	Once a year	Once every six months
0	1	2	3

Other schedule (please specify):
4

38. How often do consumer advisory boards affiliated with your office meet? (Circle)

Yearly	Once every six months	Once a month	Other schedule (please specify):
1	2	3	4

39. Approximately, how many consumers, currently being served in your office, would benefit from the use of a language other than English?

______

40. Approximately, how many consumers, currently being served in your office, would benefit from the use of alternative modes of communication? _____

41 What resources are available to counselors to conduct the assessment and planning process in a language other than English and/or in alternative mode of communications (e.g. translators, interpreters, etc.)?

Assistive Technology and Accommodation: *Items 42-46 refer to assistive technology and accommodations the Amendments as Rehabilitation Technology Services to be used throughout the rehabilitation process. Examples of* ***assistive technology*** *include a whole range of high and low tech devices that assist individuals in their daily lives such as: wheelchairs, computer devices and software, reachers, and prosthetics.* ***Accommodations*** *include strategies or devices that allow an individual with some limitation to participate more fully in his or her job placement, services, or the rehabilitation process itself;* ***examples include: conducting business in a language other than English, using communication support or devices, restructuring schedules or job descriptions***

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	**How, specifically, has this practice changed?**
42.	Provision of necessary assistive technology and accommodations for consumers at each stage in the rehabilitation process.	1 2 3	
43.	Active involvement of the consumer in developing necessary assistive technology and accommodations.	1 2 3	
44.	Training to counselors and other related service personnel on assistive technology and accommodations.	1 2 3	

Additional Items about Assistive Technology and Accommodations

45. Please list in rank order the most frequently needed assistive technology for consumers served in your office.

______	______	______	______	______
1	2	3	4	5
Most Frequent				**Least Frequent**

46. Please list in rank order the most frequently needed accommodations for consumers served in your office.

____________	____________	____________	____________	____________
1 **Most Frequent**	2	3	4	5 **Least Frequent**

***Serving Those Who Have Not Been Adequately Served In The Past**: The 1992 Rehabilitation Act Amendments emphasize the need to expand vocational rehabilitation services to groups of individuals who have not been served or who have been under-served in the past. These groups include people from minority backgrounds and those with the most severe disabilities. Items 47-51 ask for information on your office's service to those who may have not been adequately served in the past.*

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	**How, specifically, has this practice changed?**
47.	Outreach efforts to groups or communities of individuals who have not been served or have been under-served in the past. (e.g. minorities and those with the most severe disabilities.)	**1 2 3**	
48.	Efforts to address the rehabilitation needs of individual who are HIV+ or who have AIDS.	**1 2 3**	
49.	Technical assistance to employers about issues related to employees with AIDS or HIV.	**1 2 3**	

Additional Items About Serving Those Who Have Not Been Adequately Served In The Past

50. Indicate groups whom you consider have **not** been adequately served by your agency in the past (individuals with the most severe disabilities, African-American, Latino, people with AIDS/HIV, etc.).

1.___________ 2.___________ 3.___________ 4.___________ 5.___________

51. Does your state have a process by which individuals with the most severe disabilities are prioritized for receive services first (order of selection)?

Yes ______ No ______

If your state has an order of selection process:

a. When was the order of selection process implemented (start date)? ______/______
(Month/Year)

b. In the box below, briefly describe the criteria used to determine which consumers are those with the most severe disabilities (if additional space is needed, please attach):

If your state does not currently have an order of selection process:

c. Are there plans to implement an order of selection process?

Yes _________ No__________

d. If no, what is the anticipated start date for the order of selection process? ______/______
Month / Year

If you have additional comments, please attach additional pages.
Thank you very much for your time and effort!

INSTITUTE FOR
COMMUNITY
INCLUSION

Appendix B

Counselor Survey Instrument

VR Counselor: Respondent Information

Your answers to the following questions will help us better understand our respondents and their caseloads.

1. Your Job Title: ____________________ 2. When did you begin your current job? ______/______ (Month / Year)

3. Are you a Certified Rehabilitation Counselor (CRC)? Yes___ No____

4. What is your racial/ethnic background?

______ White
______ Black
______ American Indian/Alaskan Native
______ Asian/Pacific Islander
______ Other

Are you of Hispanic Origin: Yes___ No____

5. What is your gender? Male ______ Female _____

6. How would you classify the geographic environment served by the office where you work? (Check One)

Urban/Suburban _____ Rural ________ Both ______

7. How many individuals are currently on your active caseload (in any status category)? ______

8. Please identify the type of cases you handle in your caseload (check al! that apply)?

General Mix _____ Severe Mobility Impairment _______ HIV/AIDS ______

Substance Abuse _______ Traumatic Brain Injury ______ ADD/LD/ADHD_

Other (Please specify) _____________

9. In what ways has your caseload changed since 1992? (circle one)

a. Severity of disability Yes No Don't Know If yes, how ______________________________

b. Cultural or ethnic diversity Yes No Don't Know If yes, how ______________________________

c. Number of people closed "rehabilitated" (status 26) in a year Yes No Don't Know If yes, how ______________________________

d. Number of people closed not rehabilitated" (status 28, 30) in a year Yes No Don't Know If yes, how ______________________________

Critical Aspects of the 1992 Rehabilitation Act Amendments

The items in this questionnaire reflect practices highlighted in 1992 Rehabilitation Act Amendments. **Please respond to these items as they relate to your practice with the consumers whom you serve.** Please provide as much descriptive information as you can about how the changes are being/have been addressed in your practice. Feel free to attach additional pages if necessary.

The rating scale measures the extent to which the following practices or guidelines has changed since the 1992 Rehabilitation Act Amendments. Please circle the number that best describes the amount of **change** that has taken place in the way you carry out these practices.

1 = No change **2 = Some change** **3 = A great deal of change**

A number of these items will be asking for information about the last ten (10) applicants (i.e., status 02) or closures (i.e., status 08, 26, 28, and 30) from your caseload. Do you feel these individuals accurately represent your caseload as a whole?

Yes No

If no, please explain (For example, your last ten closures include a greater number of individuals with Traumatic Brain Injury than those with whom you have previously worked):

***Eligibility**: The 1992 Amendments reduced the maximum amount of time for an eligibility decision to sixty-days. Items 1-9 pertain to the process by which applicants' eligibility is determined and the implications of ineligibility.*

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	**How, specifically, has this practice changed?**
1.	The presumption that applicants will be able to benefit from rehabilitation services.	1 2 3	

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	**How, specifically, has this practice changed?**
2.	Methods to document and demonstration the judgment that an individual would not benefit from VR services.	1 2 3	
3.	Yearly re-evaluation of individuals who are judged ineligible for services because they are considered unable to benefit from VR services.	1 2 3	
4.	Formal process by which consumers appeal a decision of ineligibility.	1 2 3	

Additional Data on Eligibility

5. Out of your last ten (10) *applicants*, how many eligibility decisions were made within 60 days of application? ______

6. Out of your last ten (10) *applicants*, how many were determined unable to benefit from rehabilitation services ? ______

7. How many appeals regarding ineligibility have you been involved in for consumers on your case load during the last year? ______

   a. Does this number generally reflect the number of re-evaluations you have done in past years?(Circle one) Yes No

   b. If no, please explain:

8. How many re-evaluations of individuals previously closed as ineligible have you participated in during the last year? ______

a. Does this number generally reflect the number of re-evaluations you have done in past years?(Circle one) Yes No

b. If no, please explain:

9. Please indicate the extent to which you agree with the following statements about sixty day eligibility:

1 = disagree definitely, 2 = disagree somewhat, 3 = neutral, 4 = agree somewhat, 5 = agree definitely

		Circle One
a.	Sixty day eligibility has significantly streamlined the VR process.	**1 2 3 4 5**
b.	Sixty day eligibility has effectively reduced the VR bureaucracy.	**1 2 3 4 5**
c.	Informed eligibility decisions can be made during the sixty day eligibility period.	**1 2 3 4 5**
d.	The sixty day eligibility period has effectively reduced the amount of time it takes a consumer to move from applicant status into services.	**1 2 3 4 5**
e.	Service plans are developed sooner due to the sixty day eligibility period.	**1 2 3 4 5**
f.	Sixty day eligibility does not allow counselors to do comprehensive assessments.	**1 2 3 4 5**
g.	More hours of the work week are spent making eligibility decisions about applicants than before 1992.	**1 2 3 4 5**
h.	The consumers with whom you work are satisfied with the sixty-day eligibility period.	**1 2 3 4 5**

Use of Existing Information: *The 1992 Amendments encourage VR agencies to use existing information where possible throughout the rehabilitation process. This existing information can be diagnostic information from a physician or psychologist, standardized assessment, or any documentation that contributes to the eligibility decision or the rehabilitation process. Items 21-23 are related to the use of client's previous information in records in the rehabilitation process.*

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	**How, specifically, has this practice changed?**
10.	Use of existing information from other sources through out the rehabilitation process (e.g., diagnostic information, standardized assessments, etc.).	1 2 3	
11.	Consumers' responsibility for providing the VR counselors with existing information through out the rehabilitation process.	1 2 3	

Additional Data about the Use of Existing Information

12. Of the last ten (10) *applicants* in your case load, how many provided existing information that was used in the VR process? ______

13. Of the last (10) *applicants*, how many new assessments have you needed to do with clients prior to status 10? _______

14. During the last year, how many new assessments have you needed to do with clients after status 10? _______

15. Please indicate the extent to which you agree with the following statements:

1 = disagree definitely, 2 = disagree somewhat, 3 = neutral, 4 = agree, somewhat 5 = agree definitely

		Circle One
a.	Existing information is generally adequate for eligibility decision making purposes.	1 2 3 4 5
b.	The use of existing information has reduced paperwork delays during the eligibility decision process.	1 2 3 4 5
c.	The VR assessment process is easier with the use of existing information.	1 2 3 4 5
d.	The use of existing information creates a cost saving for your VR office.	1 2 3 4 5

Consumer Involvement, Assessment, and the IWRP: *The Amendments emphasize consumer involvement through out the rehabilitation process. Items 16-33 address the active involvement of the consumers as they are served by your office, the process by which appropriate services are identified, and the IWRP.*

1 = No change 2 = Some change 3 = A great deal of change

		Change (Circle One)	**How, specifically, has this practice changed?**
16.	Assessment of the consumer's needs, skills, and vocational goals occurs after eligibility has been determined.	1 2 3	
17.	Active consumer involvement in the development of the IWRP.	1 2 3	
18.	Active involvement of family members, advocates, or a representative of the consumer in the IWRP development process when necessary.	1 2 3	

Note: Counselor Perspective

1 = No change **2 = Some change** **3 = A great deal of change**

19.	Conducting planning and assessment in the native language of the individual with disabilities.	1	2	3
20.	Use of alternative formats (e.g., Braille or enlarged print) when needed.	1	2	3
21.	Activities for informing consumers of their rights under the Rehabilitation Act Amendments.	1	2	3
22.	Activities for informing consumers of their rights under the Americans with Disabilities Act.	1	2	3
23.	Strategies to make consumers aware of options and the choices of services available to them.	1	2	3
24.	Consumer choice of the agency or vendor that will provide services.	1	2	3
25.	Placement opportunities for individuals in integrated environments.	1	2	3

Additional Data on Consumer Involvement, Assessment, and the IWRP

26. Out of your last ten (10) *closures*, how many consumers collaborated with you in determining the goals and objectives on their IWRP? ____________

a. Please list ways these consumers collaborated:

27. Out of your last ten (10) *closures*, how many IWRP's included a statement in the consumers own words describing his or her involvement? _______

28. Of the last ten (10) *closures* on your case load, how many consumers had family members, advocates, or a chosen representative who participated in the IWRP process? ______

a. Please list ways in which these individuals participated:

29. Out of your last ten (10) *closures*, how many consumers needed business to be carried out in a language other than English? _____

30. Out of your last ten (10) *closures*, how many consumers needed materials produced an adapted format (e.g., Braille, large print, etc.)?

____

31. What resources were available to you in order to provide services in a language other than English or an adapted format? (e.g., translators, interpreters, etc.)?

32. Out of your last ten (10) *closures*, how many consumers chose their own agency or vendor of services from at least two choices?

______

33. Out of your last ten (10) *successfully rehabilitated closures* (status 26), how many consumers found integrated employment?

______

You've completed more than half of the questionnaire! Let us take this opportunity to thank you for your thought and effort!

Keep going!

Assistive Technology and Accommodation: *Items 35-45 refer to assistive technology and accommodations that are spoken of in the Amendments as Rehabilitation Technology Services and are to be used throughout the rehabilitation process. Examples of assistive technology include a range of high and low tech devices that assist individuals in their daily lives such as: wheelchairs, computer devices and software, reachers, and prosthetics. Accommodations include strategies that allow an individual with some limitation to participate more fully in his or her job placement, services, or the rehabilitation process itself; examples include:* ***In a language other than using communication support or devices, restructuring schedules, or adapting job descriptions.***

1 = No change **2 = Some change** **3 = A great deal of change**

		Change (Circle One)	How, specifically, has this practice changed?
34.	Provision of necessary assistive technology and accommodations for consumers at each stage in the rehabilitation process.	1 2 3	
35.	Active involvement of the consumer in developing necessary assistive technology and accommodations.	1 2 3	
36.	Conducting work place assessments as part of the identification of technology service needs.	1 2 3	
37.	Assisting employers make reasonable accommodations at the workplace.	1 2 3	

Additional data about Assistive Technology and Accommodations

38. Out of your last ten (10) *closures*, how many received assistive technology as part of their VR services? ______

39. Please list in rank order the most frequently needed assistive technology for consumers on your caseload (e.g., wheelchairs, computer devices and software, reachers, and prosthetics).

______	______	______	______	______
1	2	3	4	5
Most Frequent				**Least Frequent**

40. Out of your last ten (10) *closures*, how many received accommodations as part of their VR services? ______

41. Please list in rank order the most frequently needed accommodations for consumers on your caseload (e.g., using communication support or devices, restructuring schedules, or adapting job descriptions).

______	______	______	______	______
1	2	3	4	5
Most Frequent				**Least Frequent**

42. Please list examples of how consumers are actively involved in the process of developing their necessary rehabilitation technology services:

43. Out of your last ten (10) *closures*, how many work place assessments did you conduct? ______

44. Out of your last ten (10) *closures*, how many clients needed you to help an employer make reasonable accommodations? ______

Please list examples of how you helped these employers:

Serving Those Who Have Not Been Adequately Served In The Past: *The 1992 Rehabilitation Act Amendments emphasize the need to expand vocational rehabilitation services to groups of individuals who have not been served or who have been under-served in the past. These groups of individuals include people from minority backgrounds and those with the most severe disabilities. Items 45-53 ask for information on your office's service to those who may not have been adequately served in the past.*

1 = No Change 2 = Some Change 3 = A great deal of change

		Change (Circle One)	**How, specifically, has this practice changed?**
45.	Outreach efforts to groups or communities of individuals who have not been served or under-served in the past (e.g., individuals with the most severe disabilities, African-American, Latino, people with AIDS/HIV, etc..	1 2 3	
46.	Efforts to address the rehabilitation needs of individual who are HIV or who have AIDS.	1 2 3	
47.	Technical assistance to employers about issues related to employees with AIDS or HIV.	1 2 3	
48.	Provision of VR services to those who have the most severe disabilities first.	1 2 3	

Additional Data on Services for those who have not been adequately served in the past

49. Please list outreach strategies you have used to provide services to individuals who are members of communities or groups that have not been adequately served by your office in the past?

____________	____________	____________	____________	____________
1	2	3	4	5
Most Frequent				**Least Frequent**

50. Out of your last ten (10) *closures*, how many individuals were considered to have a severe disability? ______

The Rehabilitation Services Administration's definition of severe disability is as follows: "Individuals with severe handicaps" means an individual with handicaps: i) Who has a severe physical or mental disability that seriously limits one or more functional capacities (mobility, communication, self-care, self direction, or work skills) in terms of employability; ii) Whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and iii) Who has one or more physical or mentally disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculoskeletal disorders, neurological disorder (including stroke and epilepsy), paraplegia, quadriplegia, other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis or an evaluation of rehabilitation potential to cause comparable substantial functional limitation" (Federal Register, 1987)

51. How many individuals, currently on your case load, are you aware of as being HIV+ or having AIDS? _________

52. Please list employment issues or support needs that you and your client(s) who are HIV+ or have AIDS are addressing together.

____________	____________	____________	____________	____________
1	2	3	4	5
Most Frequent				**Least Frequent**

53. *In the last year*, how many times have you needed to provide technical assistance to employers about issues related to employees with AIDS or HIV? ________

a. Please list the types of technical assistance you have provided:

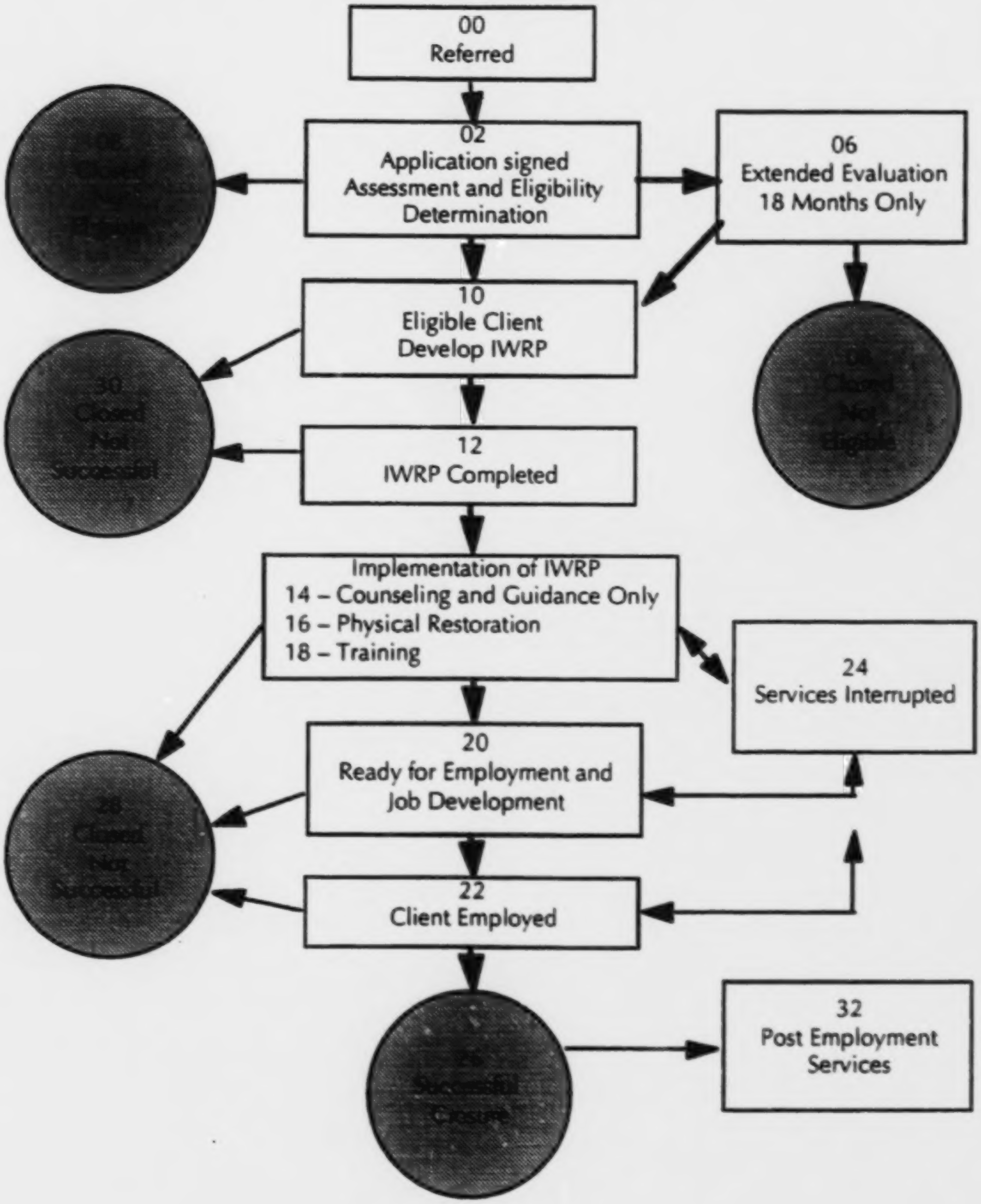
If you have additional comments please feel free to write them on the back of this sheet or attach a separate page.
Thank you for your time and effort

ICI
INSTITUTE FOR
COMMUNITY
INCLUSION

Appendix C

Status Flow in the Vocational Rehabilitation Process

Status Flow in the Vocational Rehabilitation Process


00
Referred
02
Application signed
Assessment and Eligibility
Determination
06
Extended Evaluation
18 Months Only
08
Closed
Not
Eligible
10
Eligible Client
Develop IWRP
08
Closed
Not
Eligible
30
Closed
Not
Successful
12
IWRP Completed
Implementation of IWRP
14 – Counseling and Guidance Only
16 – Physical Restoration
18 – Training
24
Services Interrupted
20
Ready for Employment and
Job Development
28
Closed
Not
Successful
22
Client Employed
26
Successful
Closure
32
Post Employment
Services

BEST COPY AVAILABLE

Institute for Community Inclusion
Children's Hospital
300 Longwood Avenue
Boston, Massachusetts 02115

617 355-6506
617 355-7940
617 355-7940 (TDD)
ici@a1.tch.harvard.edu (email)
www.childrenshospital.org/ici